

The Cape Fear



Mothers of Twins Club

MEMBERSHIP INFORMATION

Today's Date: _____

Your Last Name:		First Name:		Nickname:	
Husband's Full Name (if applicable):					
Street Address:			City:		Zip:
Home Phone:		Work Phone:		Cell Phone:	
Email Address:					
How long have you lived in the area?					
Your birthday (month, day):			Husband's birthday (month, day):		
At time of application, I am currently:		<input type="checkbox"/> Pregnant with twins <input type="checkbox"/> Pregnant with triplets <input type="checkbox"/> Other: _____ Due Date: _____		<input type="checkbox"/> A mother of twins <input type="checkbox"/> A mother of triplets <input type="checkbox"/> Other: _____	
Children's Names	Sex	Age		Birthday	
Your multiples are (circle appropriate information)					
Identical / Fraternal		Expected / Surprise		Full-Term / Pre-mature	
Is there a history of twins in your family? <input type="checkbox"/> yes <input type="checkbox"/> no				Are your twin? <input type="checkbox"/> yes <input type="checkbox"/> no	
Why are you interested in joining our club?					
How did you find our about our club?					
I would like to receive my monthly newsletter <input type="checkbox"/> via postal mail <input type="checkbox"/> via email					