



# ENTRY LEVEL REFEREE CLINIC

## REGISTRATION FORM

**PLEASE PRINT CLEARLY**

First name: \_\_\_\_\_

Family name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal code: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Year of birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Please attach the payment (\$40.00)\* to this form.

**TYPE OF CLINIC:** \_\_\_\_\_

**DATE OF CLINIC:** \_\_\_\_\_ **LOCATION:** \_\_\_\_\_

**NAME TO BE ON CERTIFICATE IF DIFFERENT THAN ABOVE:**

\*Please note that effective April 1, 2012, the Clinic Registration Fee will be \$45.00

### MSA use only:

**Clinic Location:** \_\_\_\_\_ **Host:** \_\_\_\_\_ **Clinic fee paid (\$40):**

**Paid:** cash  cheque:  **Office Receipt #** \_\_\_\_\_ **Book:**  **Mark: %** \_\_\_\_\_

**Orientation:**  **Fitness:**  **AR Clinic:**  **Certificate:**  **Badge:**  **MSA #** \_\_\_\_\_

RECEIVED

COMMENTS

\_\_\_\_\_  
\_\_\_\_\_