



Registration Form

PARTICIPANT NAME: _____

PHONE NUMBER: _____ **EMAIL:** _____

ADDRESS: _____

CITY: _____ **POSTAL CODE:** _____

EMERGENCY CONTACT NAME AND NUMBER _____

METHOD OF PAYMENT: VISA _____ AMEX _____ M/C _____

CARD NUMBER: _____ **EXPIRY DATE:** _____

CHEQUE ENCLOSED: _____ (No post dates please)

*If paying by cheque, space will not be reserved until payment is received.

DATE OF CLINIC: July 7-10 _____

August 11 - 14 _____

AGE: _____

NUMBER OF YEARS PLAYED: _____