SOLID STATE HOCKEY™

CLINIC REGISTRATION

PARTICIPANT NAME: _____ (Please print) AGE: _____

ADDRESS: _____ CITY: _____

ZIP: _____ PHONE NUMBER: _____

EMAIL: _____

PARTICIPANTS SIGNATURE: _____ DATE SIGNED: _____

POSITION PLAYED: _____ CURRENT TEAM: _____ JERSEY SIZE: _____

ANY MEDICAL RESTRICTIONS:

_____

_____

_____

FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITY AGE UNDER AGE 18 AT TIME OF REGISTRATION

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of all the named Releasees. I also understand there are NO REFUNDS. Full player HECC approved equipment is required as well as an ice hockey stick.

PARENT / GUARDIAN SIGNATURE _____ DATE SIGNED _____

COMMENTS

_____

_____

_____

DELIVER IN PERSON OR EMAIL COMPLETED FORM TO DIRECTOR@SOLIDSTATEHOCKEY.COM

SOLID STATE HOCKEY™

PAYMENT IS DUE DAY OF CLINIC. PAYMENT AMOUNT _____

MAKE CHECKS PAYABLE TO BRAD GILMARTIN. CHECK NUMBER _____

Checks returned for insufficient funds will be charged an additional $20.00 fee

CASH _____

DATE _____

PRE-PAID _____