



Officials Clinics

SIGN IN FORM

COURSE CONDUCTORS: Please ensure all requested information has been recorded - clearly.

CLINIC: _____ CLINIC LOCATION (City/Town): _____ DATE: _____

Last Name	First Name	Current Level Certified	Email Address	Club Affiliation	Initials

Course Conductors: _____ Level: _____ Course Conductor Signature: _____

Mentor: _____ Level: _____ Mentor Signature: _____