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

Course Conductors: _______________________ Level: _______ Course Conductor Signature:_________________________

Mentor: _________________________________ Level: _______ Mentor Signature:_________________________________

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