Certification Reimbursement Form

Name: _____

Telephone Number: _____

Email Address: _____

Address (incl. postal code to mail cheque):

_____

Team: _____

Position

☐ Coach ☐ Asst. Coach ☐ Trainer ☐ Team Manager

Clinic Information

Certification # _____

Type ☐ Coach ☐ Speak Out ☐ Trainer

Level (coach or trainer only) _____

Location _____

Signature _____

Receipt and copy of certification must be attached.

Submit to:

Treasurer
PO BOX 406
Carp ON
K0A 1L0