



2010 CAVALOR/USHJA CLINIC APPLICATION

DATE OF CLINIC: _____

CLINIC ORGANIZER:

Name: _____ USEF/USHJA #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

FACILITY:

Name: _____ Owner: _____

Address: _____

City: _____ State: _____ Zip: _____

Will there be a charge for use of this facility? Yes or No
If yes, what is the cost? _____

CLINICIAN:

Name: _____ USEF/USHJA #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Will the clinician be charging a fee for his/her services? Yes or No
If yes, how much? _____

ADDRESS WHERE YOU WOULD LIKE THE PARTICIPANTS GIFT BAGS SENT:

- Clinic Organizer
- Host Facility

- Other: *(please provide full mailing address)*

Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____

ADDITIONAL INFORMATION ABOUT YOUR CLINIC:

You are not required to fill out this information. Any information provided in the space below will be posted on the Clinics Calendar.

Do you have any additional information that you would like to have published on the website regarding your clinic? (i.e. the height sections that will be offered, fees, will you allow auditors, what time does the clinic start, do you have a website, etc...)
