

VIRGINIA METRO-DC COACHING EDUCATION PROGRAM

Virginia Coaching Academy

CLINIC REGISTRATION FORM

CLINIC DATE _____ MALE__ FEMALE__

CLINIC E-Clinic D-Clinic LOCATION _____
please circle one

**Please note: Those taking the clinics MUST SUBMIT A COPY of their
E Certificate or D License with this form**

(Fill in all information. Please Type or Print Clearly)

NAME _____

ADDRESS _____

CITY/STATE _____ ZIP _____

PHONE _(_____) _____ DATE OF BIRTH _____

E-MAIL ADDRESS _____

LEAGUE/CLUB AFFILIATION _____

OCCUPATION _____

PLAYING EXPERIENCE _____ COACHING EXPERIENCE _____

NOW COACHING: AGE _____ GENDER _____

METHOD OF PAYMENT: CHECK/MONEY ORDER ____ CASH ____

PLEASE NOTE: A check or money order must be paid upon registration to the course.

Being fully cognizant of the physical requirements of the Virginia Metro-DC Coaching Education Program, I am physically able to participate and hold the VCE, VYSA US Youth Soccer, and USSF, their coaching staff and each of their administrators, heirs, executors, successors, and assignors harmless for any injury or medical problem that might happen to me. I assume the risk of injury or medical problem, and I release and waive any claim that might be made by me or my heirs upon aforesaid.

SIGNATURE

In case of emergency, contact _____ phone _____

Note: The VYSA Accident Medical and Liability Insurance does not cover candidates participating in VCE activities.
