

BELLEVILLE MINOR HOCKEY ASSOCIATION
TEAM STAFF CLINIC REIMBURSEMENT FORM

NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

CLINIC ATTENDED: _____

DATE: _____

LOCATION: _____

FEE _____

TEAM APPLIED FOR: _____

POSITION: _____

PLEASE ATTACH A PHOTO COPY OF YOUR PROOF OF REGISTRATION ALONG WITH PROOF OF PAYMENT.

REFUNDS WILL BE ISSUED AFTER OCTOBER 31, 2010

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

SIGNATURE OF RECEIPT: _____

DATE: _____

TEAM ROSTER: _____

DATE REFUND ISSUED: _____

AMOUNT: _____

CHQ#: _____

JOURNAL#: _____