COACHES' LICENSE AND CLINIC REIMBURSEMENT

REQUEST FORM

Date of Request: _____ Team's age group/program: _____

First Name: _____ Last Name: _____

Course/Clinic: _____

Check Box: Head Coach: ☐ or Assistant Coach: ☐ or Goalkeeper Coach ☐ or Strength and Conditioning Coach ☐

Address: _____ apt # _____ City _____

Province: _____ Country: _____ Postal Code _____

Email: _____ Home number: _____ Cell number: _____

Explanation :

_____
_____
_____
_____
_____

Fee paid by:

☐ **Visa** ☐ **Mastercard** ☐ **American Express** ☐ **Debit/Cash**

Please note: Proof of purchase (receipt) to be submitted with request. Reimbursement will be issued via Club cheque.

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OFFICE USE ONLY: Reviewed by: _____ Approved by: _____

Amount to be Reimbursed: _____

Proof of Certification/Completion submitted: _____

1st Installment payment Date: _____ 2nd Installment payment Date: _____