I.H.S.W.C.A.

INDIANA HIGH SCHOOL WRESTLING COACHES ASSOCIATION

CLINIC REGISTRATION FORM

NAME ______________________ **SCHOOL** ____________________

e-mail address (please print) ______________________________

HOME ADDRESS ______________________________________

CITY ____________________ **STATE** _____ **ZIP** ____________

PHONE(___)_________ **CELL (___)** ___________

Head ___ **Assistant** ___ **Jr.High** ___ **Official** ___ **Other** ___

School Year____________ **Amount Sent** _____________

Individual Clinic - $100.00 _____ **Staff (2-5) - $95.00 per coach** _____

$90.00 per coach - 6 or more coaches - _______

Make checks payable to I.H.S.W.C.A. and send to:

J.D. Minch - IHSWCA Sect/Tres
North Montgomery HS
5945 US 231 North
Crawfordsville, IN. 47933

MEMBERSHIP(S) ARE INCLUDED WITH THE 2009 FALL CLINIC
PLEASE DO NOT SEND CLINIC REGISTRATION ON OR AFTER -
THURSDAY, OCTOBER 8, 2009
YOU MAY FAX YOUR REGISTRATION WITH NAMES AND SCHOOL TO ME AT **765-362-6710** AND THEN BRING MONEY WITH YOU ON THURSDAY, OCT. 14, OR FRIDAY, OCT. 15, 2009