

**Preregistration Fee:** $75.00 (Clinic & Hall of Fame Banquet)

**Late Registration:** (At Door) $90.00 (Membership is included)

**MAKE PAYABLE TO: OHSBCA**

**THERE WILL BE NO REFUNDS**

**DEADLINE: DECEMBER 23, 2016**

**2017 OHSBCA COACHES CLINIC**

**JANUARY 19-21, 2017**

**HYATT REGENCY HOTEL**

**MAIL TO:** **Pat Ewing**

**6934 Camden Dr**

**New Albany, OH 43054**

**PLEASE FILL OUT COMPLETELY. PLEASE PRINT \*\* EMAIL FOR ALL COACHES IS REQUIRED\*\***

**SCHOOL: PHONE:**

**ADDRESS: CITY: STATE: ZIP:**

**DISTRICT: (Circle one) C E NE NW SE SW College Youth/Recreation Out of State Retired**

**DIVISION: (Circle One) I II III IV**

**LEAGUE:**

**Please complete for EACH coach attending the clinic. Duplicate form if registering more than four (4) coaches.**

**Please be sure to include EACH coach’s email address. (REQUIRED\*) If no preferred mailing is designated or home address is not complete all mailings will be sent to school.**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Sent: (Circle) Home School**

**City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Coaching Position: (Circle) Varsity Asst. Varsity JV/FR JR High MS College Youth Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Membership: (Circle) New Renew Membership Years\_\_\_\_\_\_\_**

**Indicate if you plan to attend Banquet: Clinic & Banquet \_\_\_\_\_\_\_ Clinic Only\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Total # of Registrants: \_\_\_\_\_\_\_ Amt Enclosed:\_\_\_\_\_\_\_\_\_\_\_\_**

OFFICE USE ONLY: CHECK No: \_\_\_\_\_\_\_\_ Cash: \_\_\_\_\_\_ Remitter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Invoice No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL CLINIC MATERIAL TO BE PICKED UP AT THE REGISTRATION AREA AT THE CLINIC. NO MATERIALS WILL BE MAILED.**

***RECEIPTS WILL BE EMAILED***