# COACHING CLINIC REQUEST

*USE SEPARATE FORM FOR EACH CLINIC*

DATE OF REQUEST: ___________________

HOST ASSOCIATION: _____________________________________________________

CONTACT PERSON: ______________________________________________________

ADDRESS: _______________________________________________________________

PHONE: (___) ___________ ALT. PHONE: (___) ___________FAX: (___) __________

LEVEL OF CLINIC REQUESTED: ___ LOCATION: __________________________

__________________________

PREFERRED DATES: ______________ ______________ _____________

______________ ______________ _____________

SECOND CHOICE: ______________ ______________ _____________

______________ ______________ _____________

LEAGUE PRESIDENT SIGNATURE: __________________________________________

*This form must be mailed or faxed to the Kansas Youth Soccer Office for approval. A copy of the approved form will be returned to the contact person listed above. The contact person will be responsible for notifying the Kansas Youth Soccer Office of the approximate number of attendees no later than seven (7) days prior to the beginning date of the clinic.*

KANSAS YOUTH SOCCER
708 South Rogers Road, Suite C
Olathe, KS 66062
(913) 782-6434
(913) 782-0417 Fax

FOR OFFICE USE ONLY:

DATE RECEIVED BY OFFICE:_____________ BY:___________________ APPROVED: ____

STATE DIRECTOR OF COACHING:_______________________________DATE:____________