



**ARIZONA REGION OF USA VOLLEYBALL
2007-2008 REF/SCORE CLINIC VERIFICATION**



Clinic Date: _____

Age Division: _____

Club Name: _____

Team Name: _____

Please print all names – list all coaches and players who participated in this clinic only. One form per team.

Clinician: _____ **Clinician Initial:** _____ **Location:** _____

Head Coach: _____ (circle one) **Ref** **Score** **None**

Asst Coach: _____ (circle one) **Ref** **Score** **None**

Scorekeepers (3 required per team – print full name)

Referees (3 required per team– print full name)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent _____

Parent _____

Please return to the Arizona Region Office or Fax to 602 454-1427



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