



Acrobatic Gymnastics
REGION 1
ATHLETE CLINIC
Athlete REGISTRATION FORM

Print or type all information, except where signature is required. One form per club.

The Registration and Entry Fee Deadline is January 23, 2009
All forms and payments must be postmarked by this date.

Name of Club: _____

Head Coach: _____ USAG #: _____

Phone Number: _____ Email: _____

Additional Coaches Attending (USAG #): _____

Pair/Group Entries – complete the following information for each pair/group

	ATHLETE NAMES	USAG #	DATE OF BIRTH (month/day/year)	LEVEL (circle one)	EVENT (circle one)	Skills Testing (circle one)
1	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	Level 5 Level 6 Level 7 Level 8 Level 9 Level 10 Elite JONT/NT Member	WP MP MXP WG MG	Testing 10 Testing Elite
2	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	Level 5 Level 6 Level 7 Level 8 Level 9 Level 10 Elite JONT/NT Member	WP MP MXP WG MG	Testing 10 Testing Elite
3	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	Level 5 Level 6 Level 7 Level 8 Level 9 Level 10 Elite JONT/NT Member	WP MP MXP WG MG	Testing 10 Testing Elite

4	_____	_____	_____	Level 5	WP MP MXP WG MG	Testing 10 Testing Elite
	_____	_____	_____	Level 6		
	_____	_____	_____	Level 7		
	_____	_____	_____	Level 8		
	_____	_____	_____	Level 9		
	_____	_____	_____	Level 10		
	_____	_____	_____	Elite		
	_____	_____	_____	JONT/NT		
	_____	_____	_____	Member		

*copy this page if additional space is needed.



Payment Form

Print or Type all information, except where signature is required. Please send with registration form confirmation. One Check per club.

Name of Club _____

Coach Contact _____ Pro # _____

**Entry fees must be postmarked by below deadline dates.
No registrations will be accepted after January 23, 2009.**

Athlete Clinic: \$50 per athlete 1st event - \$25 2nd event

JONT Member: \$20 per athlete 1st event - \$20 2nd event

Skills Testing: \$60 per pair/group

Make Checks Payable to USA Gymnastics Check #: _____

Charge: Visa Discover MasterCard AMEX

Exp. Date: ____/____

Card # _____ Amount _____

Signature of Cardholder _____

Printed Name _____

Mail or Fax Form and Fee to:

USA Gymnastics
132 E. Washington St., #700
Indianapolis, IN 46204
Attn: Acrobatic Gymnastics
(317) 237-5069 (Fax)

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