CCASH BRANCH

DAVID WILSON CAMPDRAFT CLINIC

1ST AND 2ND SEPTEMBER 2018.

NAME……..

ADDRESS……

.

CONTACT PHONE NUMBER……AGE (U18 ONLY)…….

RIDING ABILITY……..EXPERIENCED / INTERMEDIATE…

MEDICAL CONDITIONS WE NEED TO BE AWARE OF……

……

PERSON TO CONTACT IN CASE OF AN EMERGENCY…….

……..

CAMPING ($20 per night with power or $11 per night with no power)……nights

I HAVE SENT MY FULL PAYMENT VIA EFT DEPOSIT/CHEQUE…….

DATE SENT……..

ACCOUNT: COUNTY OF CUMBERLAND ASH BRANCH BSB 062-121 A/C 10965246

I UNDERSTAND THE RISK OF PARTICIPATING IN THIS CLINIC AND WILL NOT HOLD THE COUNTY OF CUMBERLAND ASH BRANCH OR COMMITTEE RESPONSIBLE IF I INCUR AN INJURY OR LOSS.

…… **……**

SIGNATURE OF PARTICIPANT **DATE**

…….. **……..**

SIGNATURE OR PARENT/GUARDIAN **DATE**