

Great Value!

Bring Your Entire Basketball and Volleyball Staffs for \$195!



Take Advantage of Early Registration!

Register before March 28, 2008 to save \$10 off the individual rate and \$25 off the staff rate.

BEFORE 3/28/2008*	AFTER 3/28/2008
EARLY Individual...\$75	Individual.....\$85
EARLY Staff.....\$195	Staff.....\$220

Chicago, IL Basketball/Volleyball – April 11-12, 2008

Which clinic(s) are you registering for? Basketball Volleyball

Select Your Registration Type: Individual Staff

Please check website for updates and changes.

IMPORTANT! Must be postmarked or received by the deadline for pre-registration prices. After the pre-registration deadline and for onsite registrations, \$10 per individual registration or \$25 per staff registration will be added to the prices above. NO REFUNDS.

REGISTRATION INFORMATION

School Name: _____ Contact Name: _____

Address: _____ Daytime Phone: (_____) _____

City: _____ State: _____ Zip: _____ Evening Phone: (_____) _____

Fax: (_____) _____ Home Email: _____

Check here if you need a registration confirmation – you must include your Email address.

STAFF INFORMATION

There is no limit to the number of coaches allowed on a staff rate, but they must coach basketball or volleyball for your school or an affiliated junior high school. Photocopy for additional coaches.

Basketball

1. _____
2. _____
3. _____
4. _____

Volleyball

1. _____
2. _____
3. _____
4. _____

I confirm that all the coaches listed above coach at the named school or affiliated junior high school. Photo ID must be presented at the clinic.

Signed by: _____
Signature of Head Coach or Athletic Director. For Staff Registrations only.

PAYMENT INFORMATION

Check for \$ _____ enclosed. Make payable to: MEGA Clinics

Amount Due: \$ _____

Purchase order # _____

Comments: _____

Pay by credit card (circle one):

Security Code (on back of card): _____

Card Number (16 digits): _____ / _____ / _____ / _____

Expiration Date: _____ / _____

Name on card: _____
printed as appears on credit card

Billing address where credit card statement is mailed:

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____

Mail to:
MEGA Clinics
PO Box 63673
Colorado Springs, CO 80962-3673
Fax to: 719-536-0073

Office Use Only

For Questions: call 888-755-6427 | visit www.megaclinic.com