Clinic Reimbursement Form

WC Member Information

Name: _____

Mailing Address: _____

Email Address: _____

Team: _____

Position: _____
(Head Coach, Assistant Coach, Trainer, Team Manager, On Ice Helper)

Clinic Information

Clinic Type: _____
(Coach 1/2 I II, Speak Out, Respect in Sport, Trainers)

Location: _____

Cost: _____

Comments: _____

Signature _____

Please scan (phone photos are fine) **receipts & certification** and email all documents, including this form, to your **level coordinator** for approval. Level coordinator will forward approved forms/receipts to TREASURER@WCMHA.CA. Reimbursements will be done by cheque and mailed out every two weeks.

If you are unable to scan documents, please print this form and provide copies of receipts & certification and drop them off in the executive mailbox in the first aid room of the Carp Arena.