We the undersigned:

|  |  |
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|  |       |

 **SURNAME & NAME FUNCTION**

Legal Representative of the Federation:

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|  |

 **NAME OF FEDERATION**

Person in charge of clinic organization:

|  |  |
| --- | --- |
|  |       |

 **SURNAME & NAME EMAIL**

|  |  |
| --- | --- |
| Date of Clinic: |       |
| Location of Clinic: |       |
| Standard of Clicic: |  |
| Approximate number of attendees: |       |

Please list the organizational matters concerning the clinic (classroom, practice field,...):

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We understand that we will be responsible for all transfer, accommodation and meal costs for the instructor.

Softball Europe will cover the travel costs of the instructor.

**Date:**

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| **REQUESTS FOR CLINICS MUST BE MADE AT LEAST 45 DAYS PRIOR TO PROPOSED DATE** |

Signature of the Legal Representative of the Federation and seal of the Federation

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| SEND TO: office@wbsceurope.org, sb\_umpiring@wbsceurope.org  |