HOCKEY ALBERTA

CLINIC QUALIFICATIONS

Hockey Canada Safety Program
Level 2 Application Form

FULL NAME: _____

DATE OF BIRTH: _____ / _____ / _____
mm / dd / yy

CURRENT CONTACT INFORMATION:

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

EMAIL: _____ PHONE: _____

FIRST AID INFORMATION PROVIDED:

LEVEL / TYPE PROVIDER

_____ _____

DATE LOCATION EXPIRY

_____ _____ _____

** PLEASE ATTACH COPIES OF ANY CARDS OR CERTIFICATES THAT YOU HAVE RECEIVED TO CONFIRM YOUR CERTIFICATION IN THE ABOVE CLINICS **

ONCE COMPLETED PLEASE EMAIL THIS FORM TO HOCKEY ALBERTA
info@hockeyalberta.ca