



ONTARIO WOMEN'S HOCKEY ASSOCIATION TRAINER CARD APPLICATION

Please mail, email or fax this signed application along with proof of certification through an authorized HTCP clinic

NAME: _____

ADDRESS: _____

CITY / TOWN: _____ PROV: _____ PC: _____

EMAIL: _____

PHONE: _____ SIGNATURE: _____

The Trainer named above has successfully completed the following HTCP Clinic:

Level I Level II Level III

CLINIC INFORMATION

CLINIC DATE: _____ CLINIC LOCATION: _____

INSTRUCTOR'S NAME: _____

The Clinic was hosted by (check one):

Alliance Hockey GTHL HNO NOHA ODHA

ODMHA OHA OHL OMHA

Other (detail) _____

INSTRUCTOR'S NAME (PRINT)

COMMENTS: _____



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