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| --- |
| **Personal Information** |
| **Last Name** |  | **First Name** |  |
| **Address** |  | **City** |  |
| **PC** |  | **E-mail** |  |
| **Primary Phone No** |  | **Cell No** |  |
| **AB Health Care No** |  |  |  |
| **Additional Family Members** |
| **Name** | **Relationship** | **Birth Date of** **Child under 18****(d/m/yr)** | **AB Health Care No** |
|  |  |  |  |
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|  |  |  |  |
| **Check Applicable Box Below** |
| New Member(s) □ | Returning Member(s) □ | Past Member □ | I am Interested in Occasional □ Volunteering  |
| **Fees** |  |  |  |
| Family | $90 | Fob deposit | N/A |
| Adult | $50 | **For office use only:** |
| Senior (60 and above) | $40 | Fob No |  |
| Junior (17 and under) | $30 |
|  |
| **Payment Information** |
| ***Registrations will only be completed when registration form and payment have both been received by email.*** ***Post-dated cheques will not be accepted.*** |
| **Method of Payment (check in box below)** |
| Cheque(payable to OTC) □ | Visa □MasterCard □ | Cash □ |
| Credit Card No |  | Expiry Date |  |
| Signature |  | PIN |  |
| Credit Card Holder Name |  | **Total Amount** |  |
| **Email registration to: info@okotokstennis.com** |
| **Medical Info** |
| **Emergency Contact** |
| Name |  | Home Phone |  |
| Relationship |  | Cell No |  |
| Are there any medical concerns or special needs that we should be aware of? | Yes □ | No □ |
| If yes, please provide details below: |
|  |
| **Waiver** |
| I, and on behalf of any other persons included under this membership, agree to abide by all OTC bylaws, rules and regulations, including proper court behaviour and dress. The instructor has the right to remove a participant if he/she deems that person to be disruptive and/or a safety concern to the participant and others. In addition, I, my heirs, executors and administrators, agree to release the OTC, its agents, servants, officers, directors, successors and assigns of and from any and all claims, demands, actions, causes of actions whatsoever which I have had, now have or shall hereafter have arising out of or relating to any loss, damage, injury including death, or ambulance service costs that may be sustained or incurred by me or any of my property while in, upon or around the premises of the OTC or any place or premises under the control or supervision of the OTC.I further confirm that I, and on behalf of any other persons included under this membership, am endorsing my informed consent and acknowledge that this form acts as proper notice to the collection, use and disclosure of my personal information (necessary to properly complete this form) for OTC purposes.I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS MEMBERSHIP. |
| Signature of Applicant |  | Date |  |