Canadian Arm Wrestling Federation

Referee Clinic Sanction Form

Clinic Host	
E-Mail Address	
Mailing Address	

City		**Province**	
Postal Code		**Phone:**	

Location of Clinic:	
Date & Time of Clinic	
Circle Type of Clinic:	**"A" Clinic "B" Clinic**

Name of CAWF Official	
Clinic Secretary:	
Confirmed Names of Evaluators:	**1)** **Level** **2)** **Level** **3)** **Level**
Confirmed Names of Table Personnel:	**1)** **2)**

Signature of Host:	**Date:**

Approved by:	**Title:**
Signature:	**Date:**