Sitting Volleyball Clinic
Registration Form

Participant Name: _____

Gender: ☐ Male ☐ Female DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Email Address: _____

Disability (if applicable):

☐ Amputation ☐ SCI

☐ Traumatic Brain Injury ☐ Other _____

Type of Mobility Device:

☐ Crutches ☐ Manual Wheelchair

☐ Walker ☐ Braces ☐ Other _____

Emergency Contact Information

First Name: _____ Last Name: _____

Cell Phone: _____

Please return registration form to:

Arizona Disabled Sports
59 E. Broadway Road, Mesa, AZ 85210
Tiffany@arizonadisabledsports.com
Fax – 480.610.2257