



NOHA/HOCKEY CANADA SPECIALTY CLINICS REGISTRATION FORM



Please Print in Ink

Date _____

SPECIALTY CLINIC(S) ATTENDED:

SKATING PUCK CONTROL SHOOTING AND SCORING SMALL AREA GAMES

Last Name Your NOHA Coach No. | | | | |

First Name Initial

Permanent Mailing Address

City Province Postal Code | | | | |

Date of Birth Sex Res.:
Month Day Year Bus.:
Fax:
Email: _____

The Northern Ontario Hockey Association is committed to respecting and protecting the privacy of our Members, their Associations, individual members, their families and our employees. The information collected on this form will be used for the sole purpose of administering the Rules, Regulations and By Laws of the NOHA/OHF/Hockey Canada and/or for the purpose of registering the individual in the program for which they have enrolled and may be used to provide them with the information necessary for participation.

