NORTHERN ONTARIO HOCKEY ASSOCIATION
HOCKEY TRAINERS' CERTIFICATION PROGRAM
PARTICIPANT FORM

Male ☐

Date of Birth _____ / _____ / _____
Month Day Year

Female ☐

Name: _____, _____ , _____
Last First Middle

Current Address: _____ _____ _____
 # Street Address or Rural Route Apt. No.

City/Town: _____ **Postal Code:** _____ **Province:** _____

Home: ( ) _____ Bus: ( ) _____

E-mail: _____

Have you ever taken an HTCP Clinic before? Yes _____ No _____

If so, please indicate trainers # T __ / __ __ __ __ __ __

Hockey Canada Branch/Division _____

OTHER RELATED QUALIFICATIONS _____

07 (_____)

01 First Aid Instructor
02 Registered Nurse
03 Medical Doctor
04 Physiologist

05 Athletic Therapist
06 Ambulance Attendant
07 Other Specify
08 First Aid Certified

What Hockey Association are you active with as a trainer? (Circle one)

OMHA OHA NOHA GTHL ODHA/ODMHA OWHA OHL HNO

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.

Fill in all available spaces and information

Trainers # T ___ / ____ ____ ____ ____ ____ ____

Clinic Date _____ / _____ / _____
m d yr

Location _____

Exp. Date ____ / _____ / _____
m d yr

Level I ☐ **(check appropriate level)**

Level II ☐

Level III ☐

Other ☐