



FAMILY & FRIENDS BASKETBALL CLINIC
Featuring: Devin Harris, Anthony Morrow & Kris Humphries
February 13, 2011

FULL TUITION MUST ACCOMPANY THIS APPLICATION. Please mail or fax payment of \$170.00, \$225.00, or \$260.00 payable to NETS BASKETBALL to: (201) 635-3300 or Nets Basketball, 390 Murray Hill Parkway, East Rutherford, NJ 07073 Attn: Jeff Scott. Refunds for any reason, less \$35.00 handling fee, will only be available until February 7, 2011. (One week prior to the start the clinic.)

PERSONAL INFORMATION (Please complete all areas.)

Adult Name _____ Adult Name _____

Child Name _____ Birth date _____ Age _____ Gender _____

Child Name _____ Birth date _____ Age _____ Gender _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Email Address _____

<u>Adult T-shirt size</u> (circle one) XXL	XL	L	M	S	Quantity _____
<u>Child T-shirt size</u> (circle one) XXL	XL	L	M	S	Quantity _____

(All Shirts are adult sizes)

MEDICAL INFORMATION REQUIRED (All lines must be completed and returned as a part of registration.)

Emergency name and phone number to be used in the event of an injury that requires emergency treatment:

Emergency Contact Name _____ Phone (____) _____

Family Physician _____ Phone (____) _____

Medical/Accident Insurance Co. _____ Policy No. _____

Address of Insurance Co. _____

Policy in Name of _____

I hereby certify that the participants listed above are in good health and may participate in all clinic activities. We will not hold the New Jersey Nets, Nets Foundation, Nets Basketball Development or any of their respective affiliates, employees, officers, directors, or agents responsible in the event of an accident or injury as a result of our participation. I also give my permission for any member listed above to be given emergency treatment at a local hospital. I understand that all pictures, videos and other media taken at the clinic is the exclusive property of the New Jersey Nets and may be used at their discretion.

Parent or Guardian Signature _____ Date _____

PAYMENT OPTIONS

Enclosed is my payment of \$ _____ to participate in the Nets Basketball Development Family & Friends Clinic.

_____ Cash	Please charge my: _____ VISA _____ MasterCard _____ American Express
_____ Money Order	Credit Card # _____ Exp. Date _____ V-Code _____
_____ Check Number	Exact Name on Card _____
	Credit Card Billing Address _____
	Signature _____ Date _____

PHONE (201) 806-7286

FAX (201) 635-3300

WEBSITE: njnets.com