PHSRA Cinch Division Membership Form

SEND FORM TO: PHSRA SECRETARY c/o
Stefanie Hollenbach
157 Shambach Rd.
Middleburg, PA 17842

Family Membership Name____

COMPETING CHILDREN ___________________________ Ages as of 8/1/2017 _______

___________________________ _______

___________________________ _______

MAILING ADDRESS ____

CITY: ____________________________________ STATE: _______ ZIP: _____________________

PHONE ___________________ EMAIL ADDRESS:____

Enclose Membership Dues $50.00/year first member-$75.00/year PER FAMILY.
Please make check payable to PHSRA

PARENTS SIGNATURE ____

TOTAL SUBMITTED $ ________________ DATE: ____

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HEALTH INSURANCE COMPANY ____
(Required for all contestants)
POLICY NUMBER ___________________ INSURNACE CO. PHONE__________________

A COPY OF YOUR HEALTH INSURANCE CARD MUST BE ENCLOSED FOR ALL MEMBERS. ALSO A COPY OF YOUR CHILD'S BIRTH CERTIFICATE MUST BE ENCLOSED FOR NEW MEMBERS.

Photo Release:
_____ I/We will allow photographs to be taken of my son/daughter that have the potential to be used in publications, advertisements, and on the PHSRA website.

_____ I/We will not allow photographs of my son/daughter to be taken for use by the PHSRA

*Signature of Parent or Guardian*____ *Date* _____________
Minors release form must be signed and notarized