



Please complete all sections of this page and return this half with payment to  
Basketball NSW, P.O. Box 198, Sydney Markets, NSW, 2129.



## 2007 Snr Waratah U16 & U17 Country General Web Regional Camp Application

Applications will only be accepted from athletes who are registered members of BNSW

**First Name:** \_\_\_\_\_ **Surname:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Postcode:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ (Home) \_\_\_\_\_ (Mobile)

\_\_\_\_\_ (Parents Work) **Sex:** Male / Female

**Date Of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Medicare No.:** \_\_\_\_\_

**Exp Date:** \_\_\_\_ / \_\_\_\_ **Pos on Card:** \_\_\_\_\_

**BNSW Rego No (compulsory):** \_\_\_\_\_ **Assoc:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Injuries:** \_\_\_\_\_

**Receipt details will be emailed to you - please provide email address here.**

\_\_\_\_\_ @ \_\_\_\_\_

**\*\*\*NO REFUNDS: Please read our refund policy on the adjoining information page\*\*\***

**TOTAL CAMP PAYMENT ENCLOSED = \$35.00 for Camp**

**TICK THE CAMP VENUE IN YOUR REGION THAT YOU WILL BE ATTENDING (TICK ONE VENUE ONLY)**

**WESTERN CAMP VENUE:**  Bathurst Saturday 01/09/2007

**CENTRAL CAMP VENUE:**  CCYC Saturday 01/09/2007

**NORTH CAMP VENUE:**  Coffs Harbour Saturday 01/09/2007

**SOUTH WEST CAMP VENUE:**  Albury Sunday 02/09/2007

**SOUTHERN CAMP VENUE:**  Shoalhaven Saturday 01/09/2007

**PLAYERS CONSENT:** I am available for the whole Snr Waratah Program and understand that I am obliged to obey all directions from the BNSW Representatives and Staff. I Understand that basketball is a vigorous, competitive sport and that injuries to participants may occur.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*Players Signature* *Date*

**PARENTS CONSENT:** I agree to my son/daughter participating in the Snr Waratah Program under the control of the BNSW Representatives and Staff. I acknowledge that basketball is a sport that may involve collision & injury and agree to camp staff taking any action deemed necessary to care for the health & welfare of my child.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*Parents Signature* *Date*

**FORMS DUE BACK: FRIDAY 24<sup>TH</sup> AUGUST 2007 – (02) 9746 1457**

Type of Credit Card: | Bankcard / Mastercard / Viscard | (please circle) or FIND ENCLOSED: CHEQUE / M/ORDER

Full Name on Card (Print): \_\_\_\_\_

Expiry Date on Card: \_\_\_\_ / \_\_\_\_ Amount of Payment: \$ \_\_\_\_\_

Number on Card: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SIGNATURE of CARDHOLDER: \_\_\_\_\_