

THJA Clinic Request

Name of the Clinic: _____

Purpose of the Clinic: _____

Date: ____/____/____

Contact Name: _____

Phone: _____

Email: _____

Location: _____

How would your clinic benefit THJA members? _____

Amount Requested: \$_____

I verify that the information contained in this application is true and correct and I acknowledge and understand that any misstatements may result in my application being eliminated from consideration. I acknowledge and understand that the acceptance of this application by the THJA remains the sole discretion of THJA.

I acknowledge that by applying for a clinic it does not automatically approve me for a clinic. I acknowledge that if I am approved for a clinic, THJA reserves the sole right to control, sell, supervise, assign (or assign to others) the right to use broadcast, televise, reproduce, transmit or disseminate all or part of this THJA clinic. I further grant to THJA the right to make use of any photographs, film or video taken or submitted of the clinic as part of the program for media and editorial purposes in promotion of the program and sport, excepting the endorsement of any product, company or service.

Signature of Applicant: _____ Date: ____/____/____

Please submit to:

Memorial Park Hunters

8552 Memorial Drive

Houston, TX 77024

Fax: (713) 683-0921

office@memorialparkhunters.com