UNITED STATES JUDO FEDERATION
EVENT MEDICAL PROFESSIONAL LIABILITY PROGRAM
ENROLLMENT FORM

NAME OF EVENT: _____ **EVENT DATES:** _____ **EVENT SANCTION #**_____

THE NAME AND SPECIALTY OF EACH DOCTOR/PHYSICIAN AND ALL OTHER HEALTHCARE PROVIDER MUST BE LISTED IN ORDER FOR COVERAGE TO APPLY.

	PRINT NAME	SPECIALTY - CHECK ONE:	
		DOCTORS/ PHYSICIANS*	ALL OTHERS HEALTHCARE**
		(SEE DESCRIPTIONS BELOW)	
1		☐	☐
2		☐	☐
3		☐	☐
4		☐	☐
5		☐	☐
6		☐	☐
7		☐	☐
8		☐	☐
9		☐	☐
10		☐	☐
11		☐	☐
12		☐	☐
13		☐	☐
14		☐	☐
15		☐	☐
16		☐	☐
17		☐	☐
18		☐	☐
19		☐	☐
20		☐	☐
21		☐	☐
22		☐	☐
23		☐	☐
24		☐	☐
25		☐	☐
26		☐	☐
27		☐	☐
28		☐	☐
29		☐	☐
30		☐	☐
	TOTAL:		

DOCTORS/PHYSICIANS AND ALL OTHER HEALTHCARE PROVIDERS MUST BE LICENSED (IN GOOD STANDING) FOR COVERAGE TO APPLY.

**DOCTORS SHALL INCLUDE ALL MEDICAL PRACTITIONERS, RESIDENT PHYSICIANS, CHIROPRACTORS AND OTHER LICENSED PHYSICIANS IN ALL SPECIALTIES.*

***ALL OTHER HEALTHCARE PROVIDERS SHALL INCLUDE PHYSICIAN ASSISTANTS (PA), NURSES, EMERGENCY MEDICAL TECHNICIANS (EMT), PARAMEDICS, ATHLETIC TRAINERS, PHYSICAL THERAPISTS, AND MASSAGE THERAPISTS.*

READ & SIGN: I UNDERSTAND THAT THE INSURANCE COMPANY WILL RELY ON THE INFORMATION CONTAINED IN THIS FORM AND ALL OTHER INFORMATION BEING SUBMITTED. I HEREBY WARRANT, REPRESENT AND CONFIRM THAT, TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION PROVIDED IS COMPLETE, TRUE AND CORRECT.

NAME OF EVENT ORGANIZER/REPORTING PARTY: _____

BY CHECKING THIS BOX, I AGREE THAT I AM THE ABOVE LISTED PARTY. ☐

(Sept 2021)

UNITED STATES JUDO FEDERATION
EVENT MEDICAL PROFESSIONAL LIABILITY PROGRAM
ENROLLMENT FORM

PAYMENT INFORMATION:

EVENT NAME: _____

EVENT DATE(S): _____

EVENT SANCTION #: _____

EVENT ORGANIZER/REPORTING PARTY: _____

TOTAL COST SUMMARY:

TOTAL # OF PHYSICIANS :	
TOTAL # OF ALL OTHER HEALTHCARE PROVIDERS :	
$50.00 X # OF PHYSICIANS =	$
$17.00 X # OF ALL OTHER HEALTHCARE PROVIDERS =	$
TOTAL AMOUNT DUE:	$

PAYMENT PREFERENCE:

☐ **CHECK:** PLEASE MAKE CHECK PAYABLE TO **UNITED STATES JUDO FEDERATION**.
ENCLOSED IS CHECK #_____ FOR $_____

☐ **CREDIT CARD:** IF YOU ARE MAKING YOUR PAYMENT BY CREDIT CARD, PLEASE COMPLETE THE FOLLOWING:

○ *VISA* ○ *MASTERCARD*

CARD NUMBER:_____
REFERENCE NUMBER (LAST 3 DIGITS ON BACK OF CARD): _____ EXPIRATION DATE:_____
I AUTHORIZE US JUDO FEDERATION TO CHARGE MY PAYMENT TO MY CREDIT CARD IN THE AMOUNT OF $_____
PRINT NAME (AS ON CARD)_____
CARDHOLDER SIGNATURE_____

MAILING INSTRUCTIONS:

PLEASE MAIL YOUR COMPLETED ENROLLMENT FORM WITH PAYMENT TO:

UNITED STATES JUDO FEDERATION
PO BOX 338
ONTARIO, OR 97914
PH: 541-889-8753

ENROLLMENT FORM AND PREMIUM MUST BE POSTMARKED WITHIN 48 HOURS AFTER THE COMPLETION OF THE EVENT.