



**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		<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>
7		<input type="checkbox"/>	<input type="checkbox"/>
8		<input type="checkbox"/>	<input type="checkbox"/>
9		<input type="checkbox"/>	<input type="checkbox"/>
10		<input type="checkbox"/>	<input type="checkbox"/>
11		<input type="checkbox"/>	<input type="checkbox"/>
12		<input type="checkbox"/>	<input type="checkbox"/>
13		<input type="checkbox"/>	<input type="checkbox"/>
14		<input type="checkbox"/>	<input type="checkbox"/>
15		<input type="checkbox"/>	<input type="checkbox"/>
16		<input type="checkbox"/>	<input type="checkbox"/>
17		<input type="checkbox"/>	<input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>
23		<input type="checkbox"/>	<input type="checkbox"/>
24		<input type="checkbox"/>	<input type="checkbox"/>
25		<input type="checkbox"/>	<input type="checkbox"/>
26		<input type="checkbox"/>	<input type="checkbox"/>
27		<input type="checkbox"/>	<input type="checkbox"/>
28		<input type="checkbox"/>	<input type="checkbox"/>
29		<input type="checkbox"/>	<input type="checkbox"/>
30		<input type="checkbox"/>	<input type="checkbox"/>
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.



**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.