

ANRC Clinic/Certification Financial Report

Name of Clinic/Certification site _____

Address _____

Date/Time _____

A. Number of /Clinic participants _____ @ \$ 5 each _____

B. Number of Certification participants _____ @ \$10 each _____

Total amount enclosed (Add lines A and B.) _____

(Payable to ANRC)

Clinic/Certification coordinator signature _____

It is the responsibility of every Instructor and/or Judge whose signature appears below to have seen that the rules of the American National Riding Commission, Inc. concerning Clinics and Certification Centers have been carried out.

Clinic Instructors

Name _____ Email Address _____

Address _____

Signature _____

Name _____ Email address _____

Address _____

Signature _____

Certification Judges

Name _____ Email _____

Address _____

Address _____

Signature _____

Name _____ Email _____

Address _____

Address _____

Signature _____

Please mail this form with the Clinic/Certification Center Participant Report and all fees due within 10 days of the Clinic of Certification Center to: Marion Lee, 705 Longfellow Dr., NE, Leesburg VA 20176.