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.