



CLUB SPORTS
MEDICAL COVERAGE PAYMENT REQUEST

Date of Submission: _____ Date of Competition: _____

Time(s): _____ Opponent(s): _____

1. Name: _____ Cost per Hour: \$ _____

Address: _____ # of Hours: _____

_____ Total: \$ _____

Social Security #: _____ - _____ - _____

2. Name: _____ Cost per Hour: \$ _____

Address: _____ # of Hours: _____

_____ Total: \$ _____

Social Security #: _____ - _____ - _____

3. Name: _____ Cost per Hour: \$ _____

Address: _____ # of Hours: _____

_____ Total: \$ _____

Social Security #: _____ - _____ - _____

Office Use Only

This is to verify that the above named Medical Provider(s) have covered the contest(s) listed. The rate of pay for offering medical services for the sport of _____ is set at \$ _____ per hour.

Approved: _____
Director of Intramurals and Club Sports

Date: _____