

COACHES SESSION

REGISTRATION FORM

Please complete and return with payment by the deadline to:
LEGENDS LACROSSE, P.O. Box 754, Brooklandville, MD 21022-0754

NAME: _____

EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SCHOOL/PROGRAM YOU COACH: _____

NUMBER OF YRS. COACHING: _____

PHONE: (H) _____ (C) _____

USLacrosse Membership #: _____ exp. date: _____

*Please check the appropriate box for your clinic.
Print and mail along with your check payable to Legends Lacrosse.
(refer to the website for specific workshop dates & deadlines)*

- Legends Coaches Session** — Offensive Movement/Plays
- Legends Coaches Session** — Goalkeeping
- Legends Coaches Session** — Defensive Play

