EPIC Entertainment & Sports

USA Volleyball
EVENT MEDICAL PROFESSIONAL LIABILITY PROGRAM
ENROLLMENT FORM

USAVolleyball
www.usavolleyball.org

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		☐	☐
2		☐	☐
3		☐	☐
4		☐	☐
5		☐	☐
6		☐	☐
7		☐	☐
8		☐	☐
9		☐	☐
10		☐	☐
11		☐	☐
12		☐	☐
13		☐	☐
14		☐	☐
15		☐	☐
16		☐	☐
17		☐	☐
18		☐	☐
19		☐	☐
20		☐	☐
21		☐	☐
22		☐	☐
23		☐	☐
24		☐	☐
25		☐	☐
26		☐	☐
27		☐	☐
28		☐	☐
29		☐	☐
30		☐	☐
	TOTAL:		

VDOCTORS/PHYSICIANS AND ALL OTHER VHEALTHCARE 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 VHEA LTHCARE P ROVIDERS SHA LL INC LUDE 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. ☐

USA Volleyball
EVENT MEDICAL PROFESSIONAL LIABILITY PROGRAM
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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 :	
$38.00 X # OF PHYSICIANS =	**$**
$11.00 X # OF ALL OTHER HEALTHCARE PROVIDERS =	**$**
TOTAL AMOUNT DUE:	**$**

PAYMENT PREFERENCE:

◯ **CHECK:** PLEASE MAKE CHECK PAYABLE TO **USA Volleyball**. 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 USA VOLLEYBALL 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:

USA VOLLEYBALL
20501 Earl Street, Suite 3
Torrance, CA
90503

PHONE: (719) 228-6800
FAX: (719) 228-6899
EMAIL: amber.scott@USAV.org

ENROLLMENT FORM AND PREMIUM MUST BE POSTMARKED WITHIN 48 HOURS AFTER THE COMPLETION OF THE EVENT.