



2010 GILBERT BOECKMANN CLINIC APPLICATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____

EMAIL: _____

REGISTRATION FEES:

3 DAYS \$450.00	\$ _____
PER DAY \$ 200.00	\$ _____
STALL RESERVATION \$100 FOR 3 DAYS	\$ _____
Audit- 1 Day \$ 25.00	\$ _____
Audit- 3 Days \$ 60.00	\$ _____

PAYMENT MUST ACCOMPANY APPLICATION. WILL ACCEPT CASH, CREDIT CARD OR CHECK.

CC # _____ EXP DATE: _____

NAME AS IT APPEARS ON CARD: _____

ZIP CODE: _____ 3 DIGIT PIN ON BACK OF CARD _____

BILLING ADDRESS _____

PLEASE INDICATE YOUR CURRENT RIDING LEVEL AND FENCE HEIGHT
DESIRED: _____

Please fax, email or mail entries to contact below:

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