USA TRIATHLON
VOLUNTEER EVENT MEDICAL PROFESSIONAL LIABILITY
ENROLLMENT FORM

NAME OF EVENT: ______________________________ **EVENT DATES:** ____________________ **EVENT SANCTION #**______________

THE NAME AND SPECIALTY OF EACH VOLUNTEER PHYSICIAN AND ALL OTHER VOLUNTEER 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:		

ALL VOLUNTEER PHYSICIANS AND ALL OTHER VOLUNTEER HEALTHCARE 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 VOLUNTEER HEALTHCARE PROVIDERS SHALL INCLUDE 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 TRIATHLON
VOLUNTEER EVENT MEDICAL PROFESSIONAL LIABILITY
ENROLLMENT FORM

PAYMENT INFORMATION:

EVENT NAME: ________________________________

EVENT DATE(S): ________________________________

EVENT SANCTION #: ________________________________

EVENT ORGANIZER/REPORTING PARTY: ________________________________

TOTAL COST SUMMARY:

TOTAL # OF VOLUNTEER PHYSICIANS :	
TOTAL # OF ALL OTHER VOLUNTEER HEALTHCARE PROVIDERS :	
$56.00 X # OF VOLUNTEER PHYSICIANS =	**$**
$20.00 X # OF ALL OTHER VOLUNTEER HEALTHCARE PROVIDERS =	**$**
TOTAL AMOUNT DUE:	**$**

PAYMENT PREFERENCE:

○ **CHECK:** PLEASE MAKE CHECK PAYABLE TO USA TRIATHLON. 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 TRIATHLON 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 TRIATHLON
ATTN: EVENT SERVICES
5825 DELMONICO DRIVE, SUITE 200
COLORADO SPRINGS, CO 80919
PH: (719) 597-9090

ENROLLMENT FORM AND PAYMENT MUST BE REMITTED TO (OR RECEIVED BY) USA TRIATHLON TWO WEEKS PRIOR TO THE EVENT START DATE