

The Michael Filipek Tennis Academy

@ Choate Rosemary Hall/Hunt Tennis Center

Wallingford, CT

June 23-August 1, 2008

ADULT CLINIC/AEROBIC WORKOUT APPLICATION FORM

Name _____
Address _____ City _____
State _____ Zip _____ Date of Birth _____
M _____ F _____ School (if applicable) _____
Telephone (H) _____ (C) _____ (W) _____
Email _____

Playing Experience: _____

Please Select Package:

Five 1-Hour Clinics (4 people w/staff instructor): \$90/person

Five 1-Hour Clinics (4 people w/Asst. Director): \$112.50

Five 1-Hour Clinics (4 people w/Asst. Director): \$144

Aerobic Tennis Workout (Six-90 minute sessions, Mon-Thur 6-7:30pm): \$140

Please Indicate Desired Day/Time (for Clinic participants only, must have own group):

Day (M-F) _____ Time (4-8pm) _____
Day(2nd Choice) _____ Time _____

Select Payment Type: Check _____ MasterCard _____ Visa _____
Amount Enclosed \$ _____

Card # _____ Expiration _____ CVV Code _____

I authorize that my credit card will be charged for the programs selected above.

Signature _____ Date: _____

I understand that neither The Michael Filipek Tennis Academy nor any person associated with the Academy is responsible for accidents and/or medical or dental expenses as a result of participation in the program. I certify that the applicant is in good health and able to participate in all activities in which he/she is enrolled.

Signature _____ Date _____

Please make checks payable and mail to:
The Michael Filipek Tennis Academy
444 17th Stret Apt 2c
Brooklyn, NY 11215