INSTRUCTORS UPDATING

Clinic/Seminar Recording Form

CanTRA Instructor Information

Name: _____ CTRAI ___ CTRII ___ CTRI ___ Coach ___

Address:_____

City: _____ Province: _____

Postal Code: _____ Tel.: (_____)_____

Email: _____

Clinic/Seminar Information

Date of Clinic/Seminar: _____

Location: _____

Name of Clinician/Instructor: _____

Number of Hours of Participation: _____

Description of Clinic/Seminar:

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY CLINICIAN / INSTRUCTOR

I hereby certify that _____ has completed hours as stated above.

Signature: _____