REGISTRATION FORM

Personal Information:

1. - First Name: _____Last Name: _____

Other Names: _____

Date of Birth: (DD/MM/YYYY) _____

2. Gender: [ ] Male [ ] Female **Nationality:** _____

3. Address:

- Street Address: _____
- City: _____
- Country: _____

4. Contact Information:

Phone Number(s): _____ Email Address: _____

Competition Details:

5. Weight Class:

[ ] Lightweight (90 to 200 lbs)

6. Arm Preference:

[ ] Right Arm [ ] Left Arm [ ] Both Arms

7. Experience Level:

[ ] Beginner [ ] Intermediate [ ] Advanced

For more enquiries please contact: 0503951002

8. Club/Team Name:

- (If applicable) _____

Medical Information:

9. Do you have any medical conditions that the organizers should be aware of?

[ ] Yes [ ] No

- *If yes, please specify:*

_____

_____

Emergency Contact Information:

10. - First Name: _____ Last Name: _____

Other Names: _____ **Relationship:** _____

11. Phone Number(s): _____

Waiver and Consent:

12. ***I, _____hereby agree to abide by the rules and regulations of the armwrestling competition and understand that participating in this event is at my own risk. I release the organizers from any liability for injuries or damages incurred during the competition.***

Signature:

_____

For more enquiries please contact: 0503951002