

CLINIC APPROVAL FORM

___ Qualifying Rodeo ___ District Rodeo X Clinic

Clinic Name _____

CLINIC DATES _____

****Arena Name or Street Address** _____
(must be filled in or NHSRA will not approve)

PERSON TO SUPERVISE Name _____
 Address _____

 Phone _____
 Email _____

NEAREST HOSPITAL Name _____
(all information must be filled in completely)
 Address _____

 Phone _____

STOCK CONTRACTOR Name _____

SPONSORING ORGANIZATION _____

Complete Form and Send To:
MHSRA State office
PO Box 264
Roy, MT 59471
Phone/Fax: (406) 464-2686
Email: mhsra@mhsra.com

NOTE: Committee must submit this completed approval form at least 60 days in advance to the MHSRA State Office before the clinic will be approved and sanctioned.