OFFICIAL'S CLINICIAN PAY SHEET

Florida Region of USA Volleyball, Inc.

Instructions: Complete a separate pay sheet for each clinic.
All information below must be completed!

Clinician Name: _____

Mailing Address: _____

City: _____ ST: _____ Zip: _____

SSN: _____ TEL: _____ E-mail: _____

EVENT DATE: _____ # OF ATTENDEES: _____

EVENT LOCATION: _____

CLINIC CHECKLIST: (All items below must be completed before payment will be issued)

__ Official USAV PowerPoint Presentation Used

__ Approved Clinician Attire Worn

__ USAV Rule Books (DCR) Distributed

__ Attendance Roster(s) Attached

PAYMENT INFORMATION:

__ Official's Clinician Fee ($150 Head Clinic, $100 Asst. Clinician) $_____

__ Lodging Reimbursement (Must be more than 100 miles away and must be preapproved) $_____

__ Mileage ($0.545) per mile) Miles: _____ $_____

__ Copies/Printing/Supplies (Receipts must be attached) $_____

__ Other (Describe: _____) $_____

TOTAL DUE: $_____

By signing below I agree that all the information above is accurate and true to the best of my knowledge.

Official's Clinician Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Amount Paid: _____ Ck #: _____ Date Paid: _____ Initials: _____

E-mail completed form to: paysheets@floridavolleyball.org
Tel: (352) 742-0080 Web: www.FloridaVolleyball.org