

**USA TRACK & FIELD
EVENT MEDICAL PROFESSIONAL LIABILITY
ENROLLMENT FORM**

NAME OF EVENT: _____ EVENT DATES: _____ EVENT SANCTION # _____

THE NAME AND SPECIALTY OF EACH PHYSICIAN AND ALL OTHER HEALTHCARE PROVIDER MUST BE LISTED IN ORDER FOR COVERAGE TO APPLY.

	PRINT NAME	SPECIALTY - CHECK ONE:	
		DOCTORS/ PHYSICIANS*	ALL OTHERS HEALTHCARE**
		(SEE DESCRIPTIONS BELOW)	
1		<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>
7		<input type="checkbox"/>	<input type="checkbox"/>
8		<input type="checkbox"/>	<input type="checkbox"/>
9		<input type="checkbox"/>	<input type="checkbox"/>
10		<input type="checkbox"/>	<input type="checkbox"/>
11		<input type="checkbox"/>	<input type="checkbox"/>
12		<input type="checkbox"/>	<input type="checkbox"/>
13		<input type="checkbox"/>	<input type="checkbox"/>
14		<input type="checkbox"/>	<input type="checkbox"/>
15		<input type="checkbox"/>	<input type="checkbox"/>
16		<input type="checkbox"/>	<input type="checkbox"/>
17		<input type="checkbox"/>	<input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>
23		<input type="checkbox"/>	<input type="checkbox"/>
24		<input type="checkbox"/>	<input type="checkbox"/>
25		<input type="checkbox"/>	<input type="checkbox"/>
26		<input type="checkbox"/>	<input type="checkbox"/>
27		<input type="checkbox"/>	<input type="checkbox"/>
28		<input type="checkbox"/>	<input type="checkbox"/>
29		<input type="checkbox"/>	<input type="checkbox"/>
30		<input type="checkbox"/>	<input type="checkbox"/>
TOTAL:		<input type="checkbox"/>	<input type="checkbox"/>

ALL PHYSICIANS AND ALL OTHER HEALTHCARE PROVIDERS MUST BE LICENSED (IN GOOD STANDING) FOR COVERAGE TO APPLY.

**DOCTORS SHALL INCLUDE ALL MEDICAL PRACTITIONERS, RESIDENT PHYSICIANS, CHIROPRACTORS AND OTHER LICENSED PHYSICIANS IN ALL SPECIALTIES.*

***ALL OTHER HEALTHCARE PROVIDERS SHALL INCLUDE PHYSICIAN ASSISTANTS (PA), NURSES, EMERGENCY MEDICAL TECHNICIANS (EMT), PARAMEDICS, ATHLETIC TRAINERS, PHYSICAL THERAPISTS, AND MASSAGE THERAPISTS.*

READ & SIGN: I UNDERSTAND THAT THE INSURANCE COMPANY WILL RELY ON THE INFORMATION CONTAINED IN THIS FORM AND ALL OTHER INFORMATION BEING SUBMITTED. I HEREBY WARRANT, REPRESENT AND CONFIRM THAT, TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION PROVIDED IS COMPLETE, TRUE AND CORRECT.

NAME OF EVENT ORGANIZER/REPORTING PARTY: _____

BY CHECKING THIS BOX, I AGREE THAT I AM THE ABOVE LISTED PARTY.

PAYMENT INFORMATION:

EVENT NAME: _____

EVENT DATE(S): _____

EVENT SANCTION #: _____

EVENT ORGANIZER/REPORTING PARTY: _____

TOTAL COST SUMMARY:

TOTAL # OF PHYSICIANS :	
TOTAL # OF ALL OTHER HEALTHCARE PROVIDERS :	
\$56.00 x # OF PHYSICIANS =	\$
\$20.00 x # OF ALL OTHER HEALTHCARE PROVIDERS =	\$
TOTAL AMOUNT DUE:	\$

PAYMENT PREFERENCE:

- CHECK OR MONEY ORDER:** (PLEASE MAKE CHECK PAYABLE TO USA TRACK & FIELD)

ENCLOSED IS CHECK # _____ FOR \$ _____

- CREDIT CARD:** (VISA ONLY) *FOR THIS FORM OF PAYMENT, CONTACT USATF – TYLER NELSON - PH: (317) 713-9617*
- ACH:** *FOR THIS FORM OF PAYMENT, CONTACT USATF – TYLER NELSON - PH: (317) 713-9617*

MAILING INSTRUCTIONS:

PLEASE MAIL YOUR COMPLETED ENROLLMENT FORM WITH PAYMENT TO:

USA TRACK & FIELD
ATTN: SANCTIONS
130 EAST WASHINGTON STREET, SUITE 800
INDIANAPOLIS, IN 46204
PH: (317) 261-0500
FAX: (800) 833-1466
SANCTIONS@USATF.ORG

ENROLLMENT FORM AND PREMIUM MUST BE POSTMARKED WITHIN 48 HOURS AFTER THE COMPLETION OF THE EVENT.