



WTC

CLINIC REGISTRATION FORM

Name: _____

Address: _____

Home phone: _____

Cell: _____

Email: _____

Age: (juniors only) _____

Level: _____

Requested day and time:

First choice: _____

Second choice: _____

**A deposit of \$250 is due with this application by May
30th.**

**Please mail or bring this form with your deposit to The Westport Tennis Club
1696 Post Road East, Westport, CT 06880**