City of La Puente Recreation Services Department
503 Glendora Avenue, La Puente, CA 91744
(626) 855-1550

☐ New Team

☐ Returning Team
- ☐ Sun. League
- ☐ Mon. League
- ☐ Wed. League
- ☐ Fri. League

ADULT TEAM APPLICATION

☐ BASKETBALL ☐ COED SOFTBALL ☐ COED VOLLEYBALL

1. Team Name (Print): _____ (Alternate Choice):_____

2. Team Manager:_____ Email:_____

Bus.#: _____ Cell #: _____ Home #:_____

3. Address: _____ City: _____Zip Code:_____

4. Other contact Person: _____ Email:_____

Bus. #_____ Cell #:_____ Home#:_____

5. Address: _____ City:_____ Zip Code:_____

"In consideration of the acceptance of my application for entry in the sports program and as the manager of the team herein below, I agree to the following conditions: 1. Should my team drop after the Manager's Meeting, that my deposit will not be refunded. 2. Should my team drop within 48 hours of the start of league play that my team will incur charges necessary for re-scheduling of the league and any remaining monies will be refunded to the team. 3. Should my team drop **after** the start of league play, that there will be **no** refund of league fees. 4. I also realize my responsibility to inform all players on my team of the lack of medical coverage should the team elect **not** to pick up the optional **Players Medical Benefit Fund** coverage, as it is not included in league fees. Furthermore, I realize my responsibility to inform all my players of all league rules, the Players' Code of Conduct and to have all players on my team read and sign the waiver on the Team Roster or Add/Drop sheet." "By affirming my signature below, I verify that I have read and understand the aforementioned statement and will comply with its agreement. I also accept my responsibility, on behalf of my team, to pay all league fees and expenses accrued by my team including any charges or expenses incurred by the "City" in the collection of same."

Managers Signature: _____ Date:_____

FOR OFFICE USE ONLY

DEPOSIT	DATE:_____	PAID BY:_____	$:_____
ENTRY FEES	DATE:_____	PAID BY:_____	$:_____
FORFEIT FEE	DATE:_____	PAID BY:_____	$:_____
MEDICAL COVERAGE	DATE:_____	PAID BY:_____	$:_____
ROSTER SUBMITTED	DATE:_____	PAID BY:_____	$:_____