COLUMBIA UNIVERSITY
CLUB SPORTS

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CLUB SPORTS
MEDICAL COVERAGE PAYMENT REQUEST

Date of Submission:_____ Date of Competition:_____

Time(s):_____ Opponent(s):_____

1. Name:_____ Cost per Hour: $_____

   Address:_____ # of Hours:_____

   _____ Total:$_____

   Email: _____

   Phone #:_____

   Social Security #:_____-_____-_____

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2. Name:_____ Cost per Hour: $_____

   Address:_____ # of Hours:_____

   _____ Total:$_____

   Email: _____

   Phone #:_____

   Social Security #:_____-_____-_____

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3. Name:_____ Cost per Hour: $_____

   Address:_____ # of Hours:_____

   _____ Total:$_____

   Email: _____

   Phone #:_____

   Social Security #:_____-_____-_____

Office Use Only

This is to verify that the above named Medical Provider(s) have covered the contest(s) listed. The rate of pay for offering medical services for the sport of _____ is set at $_____ per hour.

Approved:_____ Date:_____

Director of Intramurals and Club Sports