



2008 WSWM SKILL DEVELOPMENT GRANT

POST EVENT REPORT

Name of Event: _____

Name/Type of Event: _____ # of Participants _____

Location of event: _____ Date of Event: _____

Clinician: _____ Host Club: _____
(Must be level 1 technical certified)

Did the Clinic meet your needs: Yes: No:

Where you satisfied with the quality of instruction received: Yes: No:

Would you like to hold another clinic in the future? : Yes: No:

Please feel free to comment on how this grant program can be improved for future clinics:

IMPORTANT:

All participants of these events **MUST** be WSWM Associate members. All clinic participants must complete a WSWM Membership Form and pay the appropriate fee. Forms and fees must be submitted to the WSWM office prior to the grant being processed.

Revenue:
Participant fee: _____

WSWM Grant: \$ 150.00

Club Support _____

Other: _____

Total: _____

Expenses:
Facility: _____

Boat/Gas: _____

Coach: _____

Other: _____

Total: _____