



2012 ORLANDO VENOM
Tryout Registration
www.orlandovenom.com

CHECK ALL TRYOUT(S) YOU WISH TO PARTICIPATE IN:

Jan 28/29 Feb 11/12 Feb 25/26

Name: _____ Date of Birth: _____

Daytime Phone: () _____ Mobile Phone: () _____

Email Address: _____

(Email address that is checked daily.)

Primary Mailing Address: _____

City: _____ State: _____ Zip: _____

Position Player: **(circle all that apply):** 1 2 3 4 5

Height: _____ Weight: _____

List ALL injuries and surgeries during career? (Type, Date, Current condition): _____

List current & past medical conditions (asthma, diabetes, allergies, etc.): _____

US Citizen? ___Y___N Current Passport? ___Y___N Country of Issue? _____

If not a US citizen, residency status? _____

Agent Name: _____

Agent Phone: () _____ Agent Email: _____

WWW.ORLANDOVENOM.COM
 EMAIL: REBEKAH@ORLANDOVENOM.COM
 PHONE: 407.300.9672
 FAX: 407.339.5562

WINNING WAYS INTERNATIONAL
 401 CENTER POINTE CIRCLE, SUITE 1505
 ALTAMONTE SPRINGS, FL 32701



COLLEGE BASKETBALL EXPERIENCE:

College Attended: _____ Head Coach: _____

Coach Phone: _____ Coach Email: _____

Final Season of Eligibility: _____

NOTE: IBL participation could impact collegiate eligibility. Consult your coach or AD, if unsure.

College Stats/Honors/Records: _____

PROFESSIONAL BASKETBALL EXPERIENCE:

Pro Team: _____ League/Country: _____

Year(s): _____ Additional information/comments:

PAYMENT INFORMATION:

Select Method of Payment:

_____ Certified check or money order enclosed (Made payable to: Winning Ways International)

_____ Master Card or Visa Card Number: _____

Card Expiration Date: _____

Name as it appears on card: _____

Billing Address: _____



SIGNATURE REQUIRED, REGARDLESS OF PAYMENT METHOD:

Player Name: _____

Player Signature: _____

Date: _____

Tryout participants are accepted on a first-come, first-serve basis until tryout dates are filled.

Prospective players not accepted will receive a full refund of their tryout application fee; upon tryout acceptance there are no refunds. **NO EXCEPTIONS**

I hereby authorize Winning Ways International, D/B/A Orlando Venom, to act on my behalf in any emergency situation requiring medical attention. I hereby release Winning Ways International, D/B/A Orlando Venom, and its employees from any and all action or causes. or actions known or unknown, resulting in any player injuries while at Winning Ways International, D/B/A Orlando Venom, events.

PLEASE FAX COMPLETED APPLICATION TO: 407.339.5562.

REGISTRATION WILL BE CONFIRMED, VIA EMAIL, UPON RECEIPT.

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