Refund Request

Date: ____________________ Players Name: ___________________________________

Make Refund Payable to:

Name: ____

Address: ____

City: ____________________________ Province: ______ Postal Code: _____________

Contact Number (Day): ____________________ Email: ___________________________

Program: Recreational ◯ Developmental ◯ Premier ◯

Reason for request:

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All refunds are subject to a $50.00 administration fee. If your refund request is due to an injury, or other medical/compassionate reason, a doctor's note may be requested.

Once completed please:

- Return this form to L02 – 1311 Portage Avenue, Wpg, MB R3G 0V3 or email to treasurer@stcharles-soccer.com
- Allow up to 30 days for processing.
- Cheques will be mailed to the address indicated above.
- This form must be completed in its entirety.

Signature: ____

Office Use Only

Approved ◯ Denied ◯

Registration Fee:$ ____________ Admin Fee:$___________ Net Refund: $____________

Variance Explanation: _______________________________Refund by: CCard / Cheque

Authorized by: ___________________________________ Date: ______________________