UNIVERSITY CAMP/CLINIC ROSTER AND COMPENSATION FORM
(STUDENT-ATHLETE)

Sport:_____ Coach/Camp Director: _____

Projected Date(s): _____

Purpose of Camp/Clinic:

_____

_____

Student-Athlete Staff Members

Name	Bckgrd Clearance	Duties	Hrs	Compensation

(Use an attached sheet, if necessary)

I hereby certify that to the best of my knowledge, the information given is correct and complete. I understand that if I knowingly give false information, or violate CSUB or NCAA rules, my employment in the CSUB athletic department may be jeopardized.

Head Coach/ Camp Director *Signature* _____

Compliance Approval *Signature* _____