**Medical Policy Form**

**Medical Professional Details**

| Name: | Registration Number: |
| --- | --- |
| Qualification: | Club Name: |
| Contact Tel. No.: | Contact Name of Person in UCD Club liaising with you: |
| Insurance Details (Policy No. & Insurer): | |

**Activity Details**

| Activity proposed on campus and rationale: |
| --- |
| Duration of Activity: |
| Location of Activity: |

**To be completed by Medical Professional**

| I confirm that the above information is accurate:  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- |

**To be completed by UCD Sport & UCD SIRC Office**

| Stamp | Signed UCD Sport: |
| --- | --- |
| Print Name: |
| Date: |
| Signed UCD SIRC Office: |
| Print Name: |
| Date: |