ACHIEVE LACROSSE, INC.
490 Chapman Street, Suite 102
Canton, MA 02021
781.562.1905 (T) 781.562.1917 (F)

ACHIEVE LACROSSE REFUND REQUEST FORM

PARTICIPANT NAME: _____

PROGRAM NAME: _____

PROGRAM DATE/DATES: _____

REASON FOR REFUND: _____

_____

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ EMAIL: _____

NAME OF PERSON MAKING REQUEST: _____

FORM OF ORIGINAL PAYMENT

CHECK (Number and date issued): _____

CREDT CARD (Credit card receipt approval code): _____

SIGNATURE: _____ DATE: _____

All refunds are subject to approval. Refunds take 3-4 weeks to process. If you paid by check or cash a check for your refund amount will be mailed to that address. If you paid be credit card, the charges will be applied back to the card of which payment was made. All checks will be made payable to the person the original payment was made.

League and Clinic refunds will be 75% of the program cost if this form is received 14 days before the start of the program. Gear Up refunds will be 75% of the program cost if this form is received 21 days before the start of the program. Tournament refunds will be 50% of the tournament fee paid if this form is received 30 days before the tournament start date.

FOR ADMINISTRATIVE USE ONLY: DO NOT WRITE BELOW THIS LINE.

Date Approved: _____ Approved By: _____

Date Processed: _____ Processed By: _____

Original Receipt Reference: _____ Refund Receipt Number: _____

Amount Refunded: $_____