Refund Request Form

Season: Spring / Fall 20___ *(circle one)*

Player Name: ______________________________

Team / Age Group: ________________ **B / G** *(circle one)*

Reason for Request: ____

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Refund Mailing Address:
Name: ______________________________________
Address: ____________________________________
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Refund Policy: Requests must be made in writing prior to the first scheduled game. All requests are subject to approval by the Board of Directors. Refund distribution dates are Sept 30th and April 30th.

Mail this form to Salem Youth Soccer, PO Box 8003, Salem, MA 01970