BV-06	CEV BEACH VOLLEYBALL ACCREDITATION OF A DOCTOR / PHYSIOTHERAPIST	

The National Federation of ___________________________ requests accreditation for the following person:

LAST NAME		FIRST NAME	
DATE OF BIRTH		NATIONALITY	
EMAIL			

as **doctor** **physiotherapist** of the following team:

Shirt #	FIVB #	Last name	First name
1			
2			

The accreditation is requested for the following competition(s):

	DATE	EVENT CATEGORY	VENUE / COUNTRY
		Masters	
		Masters	
		Masters	
		Masters	
		European Championship Final	
		U______ European Championship	
		Satellite	
		Satellite	
		Satellite	
		Satellite	
		CEV Continental Cup, Round ____	

Name of the President and/or Secretary General (printed)

Signature of the President and/or Secretary General

Date and Venue

Seal of the National Federation

The accreditation request will be granted by the CEV Medical Commission on presentation of the diploma/university grade (original copy plus translated in English copy) and a recent passport photo.

The request is subject to confirmation by CEV and entitles the person concerned to use the services and access the areas explicitly provided to the specific category.

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