New Jersey Youth Soccer

Concussion Awareness Program
Club Certification

PLEASE PRINT

Club Name: _____

Club Number: _____

Concussion Awareness Program Coordinator:

Name: _____

Address: _____

Town: _____ State: _____ : Zip_____

Phone: ( )_____

I certify that the club named above has reviewed the Certificate of Completion from one of the online training courses in Cocussion Awareness for every coach associated with our organization.

_____ Date: _____

Signature

Attach the following documentation

A list of names of every coach for which you reviewed the Certificate of Completion in Concussion Awareness.

THIS FORM MUST BE RECEIVED IN THE NJYS OFFICE BY OCTOBER 15th EACH YEAR
FAILURE TO COMPLY WILL PLACE YOUR CLUB
"NOT IN GOOD STANDING" WITH NJYS