Pacific Southwest Judo Association

WILL BE HOSTING CLINICS AND JUDGE CERTIFICATION TO BE GIVEN BY:

Sensei Eiko Shepherd, 8th Dan

Friday, November 18, 2016 6 PM TO 9 PM – Itsutsu No Kata

San Shi Dojo, 150 Cedar Road, Vista. CA 92083

Saturday, November 19, 2016 10 a.m. to 4 p.m. – Koshiki No Kata

Kata Judge Certification will be conducted for interested judoka from:

4:30 p.m. to 6:30 p.m.

San Shi Dojo, 150 Cedar Road, Vista. CA 92083

And

Sunday, November 20, 2016 8:30 a.m. to 11:30 p.m. – Ju no Kata

Migoto Judo Dojo, 2517 Windward Way, Chula Vista, CA 91914

Clinic Fees: One Clinic $25.00 Two Clinics $50.00 Three Clinics $75.00

For Additional information please contact Bruce Knight via email at ukemi7@outlook.com or Phone (619) 368-9812

Eligibility: These activities are open to all current members of United States Judo Federation, USA Judo, and United States Judo Association (Participants must show proof of Membership)

Note: Itsutsu and Koshiki no Kata are advanced Kodokan Kata and can be practiced by Judoka ages 13 and above with good ukemi skills. Ju no Kata can be performed if you have basic knowledge of the Ogoshi.

SANCTION # 16-11-13

PACIFIC SOUTHWEST JUDO ASSOCIATION

Circle the session(s) you will be attending, include a check for the appropriate clinic(s) fee(s) and mail to:

Kata Clinics
c/o Bruce Knight
12165 Cimbria Way
Lakeside, CA 92040

Itsutsu no Kata-Nov 18, 2016 **Koshiki no Kata**-Nov 19, 2016 **Ju No Kata**-Nov 20, 2016

REGISTRATION FORM

Please print legibly

Name _____Date of Birth ___/___/___
M D Y

Sex _____ Phone ( ) _____ e-mail address _____

_____
Street City

State _____ Zip _____

Judo Rank _____Club _____

Instructor _____ Judo Rank _____

USJF No. _____ USJI No. _____ USA Judo No. _____

Expiration date of membership: ___/___/___

Yudanshakai _____

In case of emergency contact:

_____
Name Relationship

Address _____
Street City State Zip

Phone ( ) _____ _____

Disability or Special Assistance

If assistance/accommodation is needed (check off appropriate item):

_____Vision Loss/Blindness _____Hearing Loss/Deafness _____Other: Specify _____

Please specify the type of assistance/accommodation requested or name of person assisting:

_____

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