



Date: _____

Last Name: _____ First Name: _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Work/Mobile Phone: _____

EMAIL: _____

Date of Birth: _____ Age: _____ Sex: _____

Class Attending: _____ Previous Training? _____

How did you hear about our school? _____

IN CASE OF EMERGENCY

ORIGINAL
TAEKWON-DO
& FITNESS
CENTER

Name of Person to Contact: _____

Relation To Member: _____

Phone [Emergency Contact]: _____

N.Y.
STATE
HEADQUARTERS
INTERNATIONAL
TAEKWON-DO
FEDERATION

Original Taekwon-Do reserves the right to dismiss any student at any time for misconduct or for actions, which convey a bad image of this Martial Art or the Center.

I have read and understand the above information and consent to the regulations set forth by Original Taekwon-Do & Fitness Center. I hereby acknowledge that the above statements are true and correct.

[OTKD Representative]

Student (18+ years of age)
Or Parent/Guardian Signature

505
OVINGTON AVE.
BROOKLYN
NEW YORK
11209
TEL & FAX
(718) 680-6112