BROOKLYN

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GLEASON'S GYM, INC.
MASTER'S CLINIC
BOXER PROFILE

NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE #: _____ EMAIL:_____

HEIGHT: _____ WEIGHT:_____ AGE:_____

NAME OF YOUR GYM: _____

HOW LONG HAVE YOU BEEN BOXING? _____

HAVE YOU COMPETED BEFORE? YES/NO WINS_____LOSSES _____

IF YES, WHEN AND WHERE: _____

WOULD YOU LIKE TO COMPETE ON OUR SANCTIONED SHOW? _____

WHAT IS YOUR OCCUPATION? _____

EMPLOYER'S NAME:_____

WHAT SPECIFIC TOPICS WOULD YOU LIKE TO SEE COVERED AT OUR CLINIC:
_____

_____

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