Community Health and Counseling Services

Room Reservation Form

June 21-24, 2006

NAME ______________________________ PHONE _______________
(Please Print Clearly)

STREET ADDRESS ____

CITY/STATE/ZIP ____

ARRIVE ___/___/___ **DEPART ___/___/___**

ROOM TYPE REQUESTS: (Please circle one of each category)

Bed Size:	**King**	**View:**	**Ocean Front**	
	Two Doubles		**Park View**	**Non-Smoking**

ROOM RATES:

Ocean Front $165 **Park View $125** **Rollaway Bed $10 additional**

METHOD OF PAYMENT:

CHECK ONE: ☐VISA ☐MC ☐DISCOVER ☐AMEX ☐DINERS

______________________________ exp. ____/____

Signature ____

You have 24 hours prior to the date of your arrival
to cancel your reservation without being charged.

The hotel will honor the conference rate subject to
Availability for reservations received after the release date May 21th,2006

Fax: 207-347-7997

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