2019 Fall Term Early Arrival
REQUEST FORM
(All guests must check out by 10am on August 21, 2019)
Any guest who has not checked out as of 10am will be assessed a $250 fee.

Date: _______________

Name: ____________________________

E-Mail: _________________________________________________________

Telephone No:______________        Fax No:___________________________

E-mail: _________________________________________________________

Arrival Date: ________________________

Departure Date: ________________________

General Check in time is 2:00 p.m. and checkout time is 11:00 a.m.

All Beds are $50.00 per night per person
Service Needs:
- Limited: means that there are no linens (just furniture)
- Linen Package: means that you have contracted for a one time linen package, $25.00 per package

**Linen Package Includes:** Twin flat sheets, pillow with pillow case, towel, washcloth, paper bath mat, trial size shampoo and trial size soap

Limited ____________     Linen _____________

Special request? Please note in space below, I will get back with you as to whether or not we can accommodate your request.

---

Please note:
You must pay for your early arrival stay with this application. Under no circumstance will you be refunded for your stay or any portion of your stay. Once you request housing, you are responsible to pay for the entire stay.
We will not refund you.
We have very limited space and if you reserve it, you are held responsible for it. Someone else may not have been accommodated because of your request.

---

Conference Services
Summer Housing
107A John M. Clayton Hall, Newark, DE 19716
or fax to 831-2998.
In order to meet your request for Credit Card Billing, please return this completed form to our office with application. Please do NOT email this form. Please fax back to us at 302-831-2998 between 9am-5pm EST.

NAME: _____________________________ DATE:______________
BILLING ADDRESS 1: _____________________________
BILLING ADDRESS 2: _____________________________
   CITY: _____________________________  STATE: ____  ZIP: ____________

CARDHOLDER NAME: ________________________________ CARD TYPE: _______________
CARD NUMBER:  _______________________________  EXP:  _______________
   (Three or four digit code appearing in the signature SECURITY CODE: block on the back of the card, or embossed on the front.):   ______________
ADDRESS AT WHICH YOU RECEIVE YOUR CREDIT CARD STATEMENT:  if same, write SAA
STATEMENT ADDRESS 1: ________________________________________
STATEMENT ADDRESS 2: ________________________________________
   CITY: __________________________  STATE: _______  ZIP: _________

In case of a question or error in billing, it is your responsibility to contact the University of Delaware Conference Services to correct any problem. I hereby give my permission to the University of Delaware to charge the above listed card, and understand that the University of Delaware’s payment policy requires that all accounts be paid in full within thirty (30) days from the close of your function.

CARDHOLDER SIGNATURE: _X_________________________________________ DATE:   ___________________

JOHN M. CLAYTON HALL, NEWARK, DELAWARE, 19716  PHONE 302.831.2214  FAX 302.831.2998

Room Number _______________________ Guest Name _____________________________