



2009 Fattah Conference on Higher Education
Please PRINT clearly and provide all information.

SCHOOL NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FACULTY ADVISOR (1) NAME: _____

FACULTY ADVISOR'S(1) E-MAIL ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

FACULTY ADVISOR (2) NAME: _____

FACULTY ADVISOR'S(2) E-MAIL ADDRESS: _____

(providing email address is mandatory, confirmation of receiving paperwork, rooming list, and payment will be confirmed via email).

PHONE: _____ FAX: _____ CELL: _____

- ROOM RATE IS \$ 137.09 INCLUSIVE PER ROOM PER NIGHT.
HOTEL WILL ONLY ACCEPT RESERVATIONS SUBMITTED ON THESE FORMS with complete rooming list AND full payment.
RESERVATIONS AND FULL PAYMENT ARE DUE TO Stefanie Mattera BY JANUARY 23, 2009.
CANCELLATION POLICY: Must cancel 72 hours prior to arrival otherwise you will be charged one nights room and tax for each room cancelled. Cancellations must be submitted in writing to Stefanie Mattera (email is acceptable to smattera@columbiasussex.com).
MAIL RESERVATIONS, ROOMING LIST, AND PAYMENT TO: Sheraton Philadelphia City Center, 17th & Race Streets, Philadelphia, PA 19103, Attention: Stefanie Mattera Phone 215-448-2857
HOTEL WILL ONLY ACCEPT FULL PAYMENT THROUGH THE ATTENDING SCHOOL VIA school check, money orders, cashiers checks (no personal checks), and credit cards.
CHECK (Payable to: Sheraton Philadelphia City Center, 17th & Race Streets, Philadelphia, PA 19103, mail to the attention of: Stefanie Mattera)
PLEASE COMPLETE THE SUMMARY INFORMATION BELOW:

Total Rooms _____ x # of nights _____ x \$137.09 = _____

Grand Total Enclosed _____



**Sheraton
Philadelphia**
CITY CENTER
HOTEL
Phone: 215-448-2000

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SCHOOL NAME: _____

ARRIVING BY BUS OR VAN: _____

REQUESTED TIME OF ARRIVAL: _____

*Please keep in mind check in is at 3pm. We will contact the faculty advisor if earlier arrival time is available.

ROOMING FORM (please make extra copies of form if needed)

ALL INFORMATION NEEDS TO BE PRINTED CLEARLY

Room # 1	Last Name	First Name	Arrival Date	Departure Date
Occupant # 1				
Occupant # 2				
Occupant # 3				

Room # 2	Last Name	First Name	Arrival Date	Departure Date
Occupant # 1				
Occupant # 2				
Occupant # 3				

Room # 3	Last Name	First Name	Arrival Date	Departure Date
Occupant # 1				
Occupant # 2				
Occupant # 3				



CREDIT CARD FAX AUTHORIZATION

I, _____, give authorization to the Sheraton Philadelphia City Center Hotel located at 17th & Race Streets, Philadelphia, PA 19103, to charge my credit card to pay for:

(Circle all that are applicable)

Room & Tax Charges

Catering Charges:

Incidentals

Banquet Charges:

Restaurant Charge

Audio Visual Charges:

Deposit/Amount: _____

Meeting Room Rentals:

Name as it appears on credit card: _____

Credit card number is: _____

Expiration date: _____ Telephone number at billing address: _____

The billing address for this credit card is: _____

City, State and Zip: _____

Guest name is: _____

Reservation number: _____ Date of Arrival: _____ Date of Departure: _____

Please include a copy of the credit card (front & back), and a copy of a state ID card or driver's license.

A fax photocopy of this authorization shall be as valid as the original.

Guests using this authorization must present proper photo ID upon check-in.

Signature of credit card holder: _____

Date: _____

Shipping address: _____

**Authorization form cannot be processed without copy of credit card. Please fax this completed form to 215-448-2853 or mail to: Sheraton Philadelphia City Center
17th & Race Streets
Philadelphia, PA 19103
215-448-2000**