

North Atlantic Health Sciences Libraries, Inc.

OFFICIAL MEETING DATES:

Saturday, September 24, 2005 – Tuesday, September 27, 2005

THE WESTIN PROVIDENCE ROOM RESERVATION REQUEST FORM

Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ (daytime) _____ (evening)

Other Guest in Room: _____

Credit Card #: _____ Exp. Date: _____

I understand that I am liable for one night's room and tax which will be deducted from my deposit, or billed through my credit card, in the event that I do not arrive on the date indicated, or do not cancel 24 hours prior to the day of arrival.

Signature _____

No. of Rooms _____	Single/Double	\$159.00
	Triple	\$184.00
	Quad	\$209.00
	➤ Subject to applicable state and local taxes (currently 13%)	

Arrival Date _____ Departure Date _____

Check-in after 4:00 PM Check-out by 12:00 PM

Valet parking and self-parking are currently \$20.00 and per car, per night, with full in and out privileges. This rate is subject to change.

Reservations Must Be Received By: September 1, 2005
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Special Requests:

(based upon availability)

King

Two Double Beds

Handicapped Accessible

Non-Smoking

Smoking

Please mail or fax this form directly to:

The Westin Providence
One West Exchange Street
Providence, RI 02903

Attn: Reservations Department

Fax: (401) 598-8294