

HOTEL RESERVATION FORM – (AL CORDOBA NEUROSURGICAL)
REF. No. 347405

PLEASE PRINT IN BLOCK CAPITAL LETTERS

MR/MRS/MISS	FAMILY NAME	
TITLE	COMPANY NAME	
TEL. NO.	FAX NO.	
Email address		
ARRIVAL DATE	FLT. NO.	ARR. TIME:
DEPARTURE DATE	FLT. NO.	DEP. TIME

COMPLIMENTARY AIRPORT PICK-UP REQUIRED (SHUTTLE BUS) (FOR INDIVIDUAL ARRIVALS ONLY WITH PROMPT FLIGHT INFORMATION)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
PRIVATE CAR PICK UP REQUIRED (@ DHS. 250/ (FOR INDIVIDUAL ARRIVALS ONLY WITH PROMPT FLIGHT INFORMATION)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
VISA REQUIRED: VISA FEE DHS 500/-	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

CREDIT CARD DETAILS ARE REQUIRED IN ORDER TO GUARANTEE THE RESERVATION – RESERVATIONS WILL NOT BE ACCPETED WITH OUT CREDIT CARD DETAILS

CREDIT CARD NO

CREDIT CARD TYPE: _____

EXPIRY DATE _____

CARD HOLDER'S NAME _____ SIGNATURE _____

TYPE OF ACCOMMODATION REQUIRED: (PLEASE [4] YOUR CHOICE OF ROOM TYPE

DELUXE SINGLE ROOM @ DHS 1,250/- _____

- THE ABOVE MENTIONED RATES ARE ONLY APPLICABLE FOR RESERVATIONS MADE UNTIL THE 15TH OCTOBER 2008
- ALL ROOM RATES ARE SUBJECT TO 10% TAX AND 10% SERVICE CHARGE PER ROOM PER NIGHT
- AMERICAN BREAKFAST BUFFET IS AVAILABLE AT DHS. 100/.. NET PER PERSON

TERMS AND CONDITIONS:

1 NIGHT DEPOSIT PAYMENT WILL BE DEBITED TO THE CREDIT CARD SUBMITTED. BY SIGNING THIS FORM YOU AUTHORIZE THE CROWNE PLAZA DUBAI TO DEBIT THIS AMOUNT.

ANY CANCELLATIOIS WILL BE CHARGED THE FOLLOWING:

AFTER 15 TH OCTOBER 2008	50% OF THE TOTAL ROOM NIGHTS
AFTER 15 TH NOVEMBER 2008	100% OF THE TOTAL ROOM NIGHTS
NO SHOWS	100% OF THE TOTAL ROOM NIGHTS.

A limited number of rooms have been reserved for this event. All rooms are subject to availability. Rates are subject to change without prior notice. After completing this form, please fax to Crowne Plaza® Dubai at

ATTN: MS. ZEINA MENHEM
FAX No. 00971-4-3314150