CAMPUS TOWER SUITE HOTEL
Live. Like. Home.

DIRECT BILLING AUTORIZATION

Please return via fax to (780)-433-4410

Company Name: _____

Contact Name: _____

Phone #: _____ Fax #:_____

Address: _____

Province/State: _____ Postal/Zip Code: _____

Guest Information

Name: _____ Reservation #: _____

Date of Arrival: _____ Date of Departure: _____

Room Rate: _____ Number of Rooms: _____

Items requested to be billed:

Room & Tax: _____ Room, Tax & Deposit: _____ Deposit Only: _____ All Charges: _____

Phone: _____ Parking: _____ Movies: _____ Cot: _____ Extra Adult(s): _____ All Incidentals: _____

Maximum amount to be Direct Billed: _____ P.O. Number: _____

Please be advised that I authorize the above indicated charges to be billed to the company at the address provided above. I acknowledge that payment is due within 30 days of billing date and that all late payments are subject to interest charges of 1.5% per month.

Authorized Signature: _____

If covered by this form, an incidental/damage deposit of $250.00 will be held through pre-authorization on the above credit card. The deposit may be refunded based on condition of room and incidental charges on account at check out.

If the deposit is not covered by this authorization form, the guest must provide their own deposit.

For use by Campus Tower only:

Approved: YES Date: _____ Approved by: _____

NO Date: _____ Declined by: _____