THE COPPERFIELD ROOM

SCHEDULING REQUEST

Contact Name: ____________________
Organization Name: ____________________
Address: ____________________
____
Telephone Number: ____________________
Fax Number: ____________________
E-mail Address: ____________________
Event/Topic of Meeting: ____________________
Date of Event: ____________________
Room Assignment: 1 2 3 4
Number Attending: ____________________
Event Start/Finish Time: ____________________

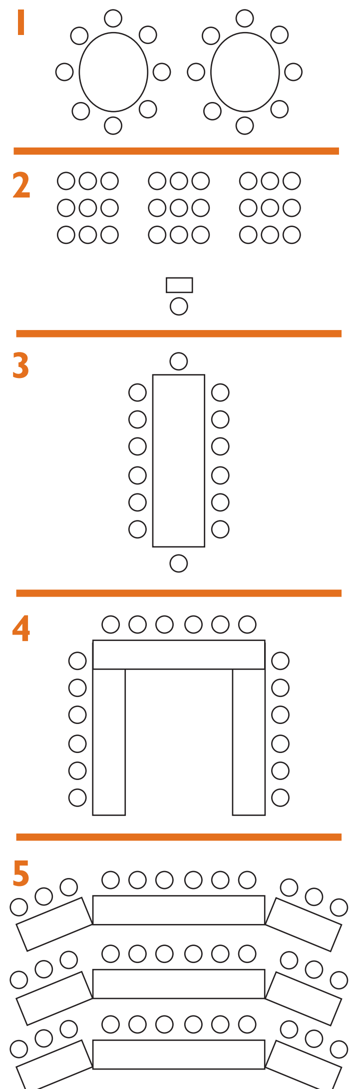
Will food and beverages be served during the meeting/event?
❏ No ❏ Yes Provided by: ____________________

Bar Service:
❏ Host Sponsored Bar ❏ Cash Bar ❏ None Requested

Media Services:
Please check equipment requested. All equipment may not be available so please ask for verification.
❏ Podium ❏ Mic/PA ❏ Screen ❏ Other ____________

Anticipated Charges:	Room Fee	____________
	Setup/Clean-up	____________
	Facility Representative	____________
	Collateral Deposit	____________
	Bartending Fee	____________
	Media	____________
	Total	____________
Non-refundable Deposit:	50% of Room Fee	____________
Remaining balance *to be paid 14 days prior to the event:*		____________

Table Layouts



Make Check Payable To: CFM Medical Properties, LLC
Late payment could result in the cancellation of the reservation.

Signature: ____________________ Date: ____________
Approval Signature: ____________________ Date: ____________

Reminder: We ask that if for any reason you need to cancel or make changes that you do so no later than 24 hours before the scheduled meeting time.

270 Copperfield Blvd, Suite 203 / Concord, NC 28025 / 704-721-7438 / www.TheCopperfieldRoom.com