



AMERICAN SOCIETY OF
SAFETY PROFESSIONALS

Company/Group Name:
Today's Date:

CONTACT / BILLING

Group Contact

Name:
Company:
Address:
City/State/Zip Code:
Phone:
Fax:
Email:

Billing Contact (if different)

Name:
Company:
Address:
City/State/Zip Code:
Phone:
Fax:
Email:

SLEEPING ROOM REQUIREMENTS

Hotel Requested: 1st Choice: _____ 2nd Choice: _____

| | Sat 9/11/21 | Sun 9/12/21 | Mon 9/13/21 | Tue 9/14//21 | Wed 9/15//21 | Thurs 9/16/21 |
|-------------------|----------------|----------------|----------------|-----------------|-----------------|------------------|
| Room Block | | | | | | |

NOTE: Please list the number of rooms needed per night. Group may be contractually and financially obligated to utilize all hotel guest rooms requested. Group agrees that, if Group's block is not entirely utilized, Group will be financially responsible for any attrition that may be incurred.

Signature: _____

Name Printed: _____

Title: _____

By signing this form, the signer is authorized to financially obligate the organization.

RETURN FORM TO
Bonnie Lipinski at blipinski@assp.org or fax to 224.725.2867

ASSP STAFF USE ONLY

Approval Date:

Contract Received by: