DALLAS COUNTY DENTAL SOCIETY
FACILITY RENTAL REQUEST FORM

Contact Name: _____

Group Name: _____

Office Phone: _____ Cell: _____

E-Mail: _____

Street Address: _____

City: _____ State, Zip: _____

Meeting Date(s) Requested: _____ Time(s): _____

Event Type: _____
(committee meeting, board meeting, lecture, workshop, etc.)

Approximate Number of Attendees: _____

Type of Room Setup: _____ No fee – Standard Classroom/Theater

_____ **$100 fee** – Change to all classroom or theater

In-house LCD Projector: Rental Fee - **$125.00** _____ yes _____ no

DCDS to Co-Sponsor and Give CE Credits _____ yes _____ no

(If yes, fill out the enclosed CE Accreditation form and return to DCDS immediately)

Will you be serving food at your event? _____ yes _____ no

If yes, name the caterer: _____

Approximate time you will come by to pick up the key: _____

ALL ROOM RENTAL FEES MUST BE SUBMITTED WITH MEETING ROOM REQUEST FORM AND MEETING ROOM RENTAL AGREEMENT AND CONTRACT

Total Amount Due $ _____ Check Enclosed: _____ Check Number: _____

Credit Card Number: _____ Expiration: ___/___ CCV: _____

Signature: _____ Date: _____
(signature authorizes charge to your account)

Print Name: _____