

HOTEL REGISTRATION FORM

Please fax or email this form to the **URBAN HOTEL ******

Port or Company: _____
Full name: _____
Address: _____ **City and Postal Code:** _____
Country: _____
Phone: _____ **Fax:** _____ **Email:** _____

LODGING OPTIONS

DOUBLE ROOM INDIVIDUAL USE

Name of the delegate: _____

Name of the accompanying person: _____

Check in: _____ **Check out:** _____ **Number of nights:** _____

PAYMENT OPTIONS

MedCruise package rate.

DOUBLE ROOM (INDIVIDUAL): € 120 per night

CREDIT CARD HOLD n. _____ **Exp. Date** _____

(Visa, Mastercard, American Express, Diners)

BANK TRANSFER TO HOTEL URBAN: Banca Popolare di Verona – Agenzia N. 103 Intestato a HOTEL URBAN SRL
CIN T ABI 05188 CAB 02200
C/C 000000080436
IBAN IT53T0518802200000000080436

IMPORTANT: include as concept of transfer "MEDCRUISE AND THE FULL NAME OF THE DELEGATE"

Hotel Reservation Cancellation Policy

Through 14 May 2008 Refund: 100%

After 15 May 2008, there will be no refund on a cancelled reservation.

PLEASE FAX OR EMAIL THIS FORM TO THE URBAN HOTEL ****

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or