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 ______________

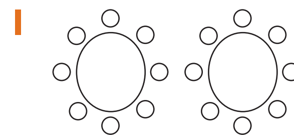
Anticipated Charges:

Room Fee	______________
Setup/Clean-up	______________
Facility Representative	______________
Collateral Deposit	______________
Bartending Fee	______________
Media	______________
Total	______________

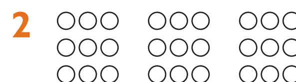
Non-refundable Deposit: 50% of Room Fee ______________
Remaining balance ______________
to be paid 14 days prior to the event:

Table Layouts

1



2



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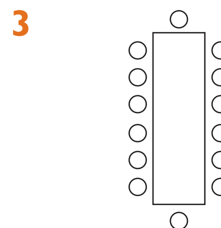

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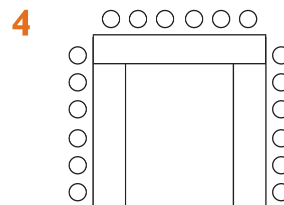

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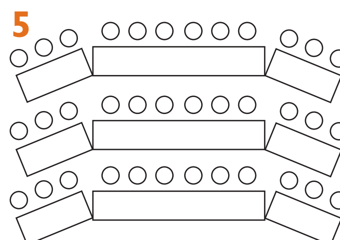

Make Check Payable To: CFM Medical Properties, LLC
Late payment could result in the cancellation of the reservation.

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