RESERVATION FORM

MEDICAL CENTER LEAGUE HOUSE

7000 Amarillo Blvd. W., Amarillo, TX 79106 Phone 806-358-3759 Fax 806-353-3540

MCLH Staff only
Date Called
Time
Initials

Cover these points with the NEW guests:

- ***The room fee is nominal per night: no tax or hotel surcharges***
- **Credit card required to secure room and if not cancelled by 6 pm credit card will be charged.**
- **We are not a "medical" facility and cannot provide medical attention, nursing or personal care.**
- **4 guests per room, children included. Additional rooms for more than four guests.**
- **Absolutely NO smoking on the property including parking lot.**
- **We have a kitchen and dining area for your use.**
- **No food or drinks allowed in rooms except for water or approval from ED**
- **No weapons, firearms or pets allowed in the building.**
- **Proof of identity is required for all adult guests staying in a room.**

Guest Information

Repeat or New Guest (circle one)

Guest Names_____

Address_____

City & State_____ Zip Code_____

Cell Phones_____

Credit Card # _____Exp Date_____CVV Code____

Confirm credit card number with guests for verification

Medical_____ Invoice/Scholarship per_____ Other_____

Arrival Date_____# of Nights_____ Arrival Time:_____

Patient's Name _____

Address_____

City & State_____ Zip Code_____

Dr Appt Hospital_____ Surgical Center_____ Dentist Funeral Nursing Home

Referred by _____Phone _____

MEDICAL CENTER LEAGUE HOUSE

Reminders
Guest Policies & Guidelines

Please Initial

NO SMOKING & NO ALCOHOL ON MCLH PROPERTY

NO FOOD OR DRINK IN GUESTROOMS, WATER ONLY

NO OUTSIDE PILLOWS OR LINENS

Guest Questionnaire for Communicable Disease

In consideration of the guest and patients going through medical issues that are staying with us we must ask some questions of you.

Please Circle One

Yes No **Have you been out of the country or visited any COVID-19 Hotspots in the last 3 months? If yes - where?**

Yes No **In last 24 hours have you had any flu like symptoms, fever, vomiting or diarrhea?**

Yes No **To your knowledge, in the last 48 hours have you been exposed to Shingles, Chicken Pox, Measles, Tuberculosis, C-diff, MRSA infection or COVID -19?**

If you come down with any of these symptoms during your stay with us, please let us know immediately!

I declare the information given on this form to be true, correct and complete to be best of my knowledge and belief.

_____ _____
Signature of Guest *Date*

_____ _____
Signature of Guest *Date*

_____ _____
Signature of Guest *Date*

_____ _____
Signature of Guest *Date*