TLC Holyland Tours, LLC
P. O. Box 14757
Knoxville. TN 37914

TLCHolylandTours.com
1-865-210-0772
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TOUR REGISTRATION

10 DAY TOUR with Pastor Dean Hermon, 5 Point Church - Easley, SC
February 4 - 13, 2020

Registration is complete upon payment of $500 deposit; $175 non-refundable for any reason. | Balance is **due in full before November 1, 2019**.
Additional cancellation penalties apply. See brochure page 4 for all Terms & Conditions.

Tour Costs total: **$4,500***

* based on double occupancy, twin bedded room. Round trip air **from Charlotte (CLT)**

Single Supplement if rooming alone add $555.00
If we cannot provide a roommate, the Single Supplement will be due.

TEAR OFF: Passenger keep upper portion for reference

Please complete all blanks below (PRINT) *Pastor Dean Hermon 5 POINT CHURCH February 4-13 2020*

Israeli law requires passport to be valid a minimum of six months after the date you return.

❒ I have applied for a passport ❒ I have applied for renewal If your passport meets the above criteria, **expiration date:** _____
00 MONTH 0000

Name as listed on passport _____ **Gender (circle)** Male Female

Title: Dr. Mr. Mrs. Ms. Miss Pastor Rev. **Name for nametag:** _____ **Passport Number**_____

Nationality_____ **Country of Issue**_____ **Occupation** _____ **Date of Birth** _____
00 MONTH 0000

Email address _____**Cell** _____

Mailing address:_____
Street or P.O. Box **City** **State** **Zip**

I want to room alone. ❒ Please pair me with a roommate. ❒ If no roommate is available, I understand I owe the Single Supplement ❒

Roommates' name _____ **Relation** _____ **Cell**_____

I understand: ❒ *Israel requires my passport be valid for at least six months after the last day of the tour.*
❒ *A scanned health insurance card (front & back) and Passport must be sent to TLC Holyland Tours by final payment due date of* ***NOV 01 2019***
❒ I have read the terms and conditions ON PAGE 4 OF THE TOUR BROCHURE and agree to them.

EMERGENCY INFORMATION

Emergency contact_____ **Relation** _____ **Phone**_____

US Physician _____ **Office Number** _____

Insurance Company _____ **Group No.**_____ **ID No.**_____

Use reverse if necessary for:
Food/Drug Allergies _____

Current Medications_____

Date:_____ **Passenger Signature:**_____

Office use only: PP_____ CK#_____ ON_____ PKT 1 _____ REG_____ MED _____ PPT _____ INS _____