



TOUR REGISTRATION

**10 DAY Bible Study and Israel Friendship Tour
 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.

Base Cost: \$3,150*

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

Adding in \$200 Trip Tips and the estimated Airport Departure Tax/Fuel Surcharge of \$695, this Tour will total: \$4,045

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)

ISRAEL FRIENDSHIP TOUR 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 _____