

MARQUEE REQUEST FORM

Name of organization _____

Name of contact person _____

Address _____

Telephone _____

Message

16 Character limited per line, including spaces

Line 1 _____

Line 2 _____

Line 3 _____

Line 4 _____

Requested dates: from _____, 20____ to _____, 20____

Signature _____ Date _____

FEES

NON-PROFIT ORGANIZATIONS - \$5.00 PER WEEK

PERSONAL ADS UP TO 3 DAYS - \$5.00 or -\$10.00 PER WEEK

ADDITIONAL FRAME-\$5.00 PER WEEK

PAYMENT INFORMATION

DATE RECEIVED: _____

APPROVED: YES _____ NO _____ FEE PAID: \$ _____

BY: _____

RECEIVED