OVERNIGHT VISITATION REQUEST

TO BE COMPLETED BY APARTMENT RESIDENT AT LEAST ***24 HOURS PRIOR*** TO ARRIVAL.

[DCC does not allow cohabitation for overnight visitations]

Apartment #:______________________ Date Completed: __________________

Apartment Resident: ____

Phone :(_____) _____-________

Guest Information* Name: __________________________________ Date of visit: _________________

Length of visit: ______________________ Expected time of arrival: ______________

Signature of Roommate approval: ____ Date: ___________

***Residents accept full responsibility for their guest's actions while in campus housing.**

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TO BE COMPLETED BY RESIDENT HOUSING DIRECTOR. Date Received: _______________

☐ Declined ☐Approved

TO BE COMPLETED BY GUEST UPON ARRIVAL. Date: ______________ Time of arrival: ________________

Name: __________________________________ Address: _____________________________________

City: ____ St: __________ Zip: ____________

Emergency Contact Information Phone :(_____) _____-________

Relationship: ____

Signature of Guest ____