

Frostproof Care Center  
17 S. Scenic Highway, Frostproof, FL 33843  
863-635-5555  
Business Office Hours - Monday thru Friday – 9:00 am to 4:00 pm

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Frostproof Care Center Community Room  
User Request Form

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**Donation \$50.00 per day, plus \$50.00 refundable deposit**

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Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Individual or Group Representative ( Must be 18 years of age or older) **MUST BE "NOT FOR PROFIT" USE**

Group Name \_\_\_\_\_ Cell # \_\_\_\_\_  
Street \_\_\_\_\_ P. O. Box \_\_\_\_\_  
City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_  
Date(s) Requested \_\_\_\_\_  
Time Requested: From \_\_\_\_\_ to \_\_\_\_\_  
Purpose of Use \_\_\_\_\_  
Approx. # attending \_\_\_\_\_ (55 to 60 people max. depending on setup)  
Key to be picked up: Date \_\_\_\_\_ Time \_\_\_\_\_

**I have read the Frostproof Care Center Community Room User Agreement Policies and agree to adhere to these policies.** (Opposite side of form)

Date Donation/Deposit Paid \_\_\_\_\_ Date Key picked up \_\_\_\_\_

Amount \_\_\_\_\_ Ck# \_\_\_\_\_ Cash \_\_\_\_\_

By: \_\_\_\_\_  
Individual or Group Representative Signature Date  
Must be 18 years of age or older

By: \_\_\_\_\_  
Frostproof Care Center Representative Date

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Key returned: Date \_\_\_\_\_  
Deposit Returned: Amount \$ \_\_\_\_\_ Date \_\_\_\_\_

By: \_\_\_\_\_  
(Key must be returned by, and deposit returned to, same person who signed Use Agreement)

By: \_\_\_\_\_ Date \_\_\_\_\_  
(Frostproof Care Center Representative)

