TEXAS MEDICAL CENTER HOUSING, INC.
LAURENCE H. FAVROT TOWER APARTMENTS
APPLICATION FOR HOUSING

PLEASE PRINT CLEARLY

Name _____ _____ _____
Last First Middle Sex E-Mail Address

Current Address:

_____ (_____) (____)_____
Street City State Country Zip Code Country Code Area Code Phone #

_____
Names Of Additional Persons You Will Bring To Live With You And Their Relationship To You

_____ (_____) (____)_____
Person To Contact In Emergency Relationship Country Code Area Code Phone #

_____ (____)_____
Hospital/School You Will Be Visiting Department Supervisor/Contact Name Area Code Phone #

Your letter of acceptance, or a letter signed by the Dean or Registrar, stating that you are/will be a full-time student at the school is required on or before you move in. If you are not a student, a letter from the institution stating your position or affiliation with the institution is required on or before you move in.

FEES: To guarantee and reserve an apartment, you must first submit this application. (No money is required to submit an application.) Then, contact the management office to confirm availability of an apartment. Upon confirmation, Favrot management will request a $25.00 non-refundable processing fee and a $400 security deposit.. A fixed administrative fee of $50 is deducted from the security deposit. Refund of the remainder of the security deposit (less lawful deductions) will be paid to Tenant or Member Institution in accordance with the terms of your Lease Contract. The security deposit will not be refunded if you cancel your reservation. **CASH IS NEVER ACCEPTED. Please mail all checks, money orders, and travelers checks to TEXAS MEDICAL CENTER HOUSING, INC., P.O. Box 973958, Dallas, TX 75397-3958. For credit card payments, complete the following:**

Amt. Authorized To Deduct From Credit Card $_____ Type Of Credit Card _____ Exp. Date _____

Cardholder Name _____ Credit Card Number _____

Type Of Apartment Desired: One Bedroom _____ Small Efficiency _____
(Number Choices in Order of Preference) Large Efficiency _____ *3-Person Shared Apartment _____(**Non-Smoking*)

The apartments are furnished with furniture. You must provide your own linens, pillows, telephone, television, cookware, shower curtain, etc. To establish telephone service, call SBC Corporation at 1-800-464-7928. For contract parking, please contact Texas Medical Center Customer Relations at 713/791-6161.

_____ _____ _____
Requested Move-In Date Anticipated Move-Out Date Who Told You About Us?

_____ _____
Signature Required To Process Credit Card Account Today's Date

Mail or Fax to: Texas Medical Center Housing, Inc., 6540 Bellows Lane, Suite 101, Houston, Texas 77030-2894 Fax: 713/799-8223
e-mail: favrot@texmedctr.tmc.edu website: www.tmc.edu/tmc-residence.html Phone: 713/797-0962
Office Hours: 11:00a to 1:00p and 3:00p to 5:00p (M-Th), 11:00a to 1:00p (Fri.) **Note: Applications will be kept on file for 90 days after requested move-in date.**

For Internal Use Only – Do not complete this box		
Application Received	**Deposit and Processing Fee Due Date & Time**	
Offer Extended	**Deposit and Processing Fee Received**	
Lease Start Date	**Scheduled Move-In Date**	**Lease End Date**