

**OTSEGO MEMORIAL HOSPITAL  
VERIFICATION OF ACCOMMODATION NEED**

THIS IS TO VERIFY \_\_\_\_\_  
Name

REQUIRES OVERNIGHT ACCOMMODATIONS. YOUR ESTABLISHMENT HAS  
AGREED TO OFFER A DISCOUNTED ROOM RATE, PAYABLE BY GUEST.

\_\_\_\_\_  
Date

\_\_\_\_\_  
OMH Staff Member Signature

\_\_\_\_\_  
OMH Staff Member Printed Name