THE 17TH ANNUAL DOWNEAST OPHTHALMOLOGY SYMPOSIUM

SEPTEMBER 21-23, 2018

HARBORSIDE HOTEL AND MARINA, BAR HARBOR, MAINE

EXHIBITOR REGISTRATION

Complete the information below in full and return form with full payment – Please print

Company Name _____ Web Site_____

Company name must be listed exactly as you wish it to appear in any official publications

Company Address _____

Contact Person_____ Tel_____ Fax_____ E-Mail_____

Representative(s) Attending Conference

Information below will be used for name badges & attendance lists

Name/Address _____

E-Mail_____Tel _____Guest Name_____

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Name/Address _____

E-Mail_____Tel _____Guest Name_____

Would prefer not to be placed near (list competitors in case they are exhibiting):_____

SPACE IS LIMITED – RESERVE NOW – DON'T MISS OUT!!!

EXHIBITOR REQUIREMENTS

EXHIBIT FEE: $1,250 (PER TABLE/SPACE) Tables 6' x 30" with skirting, chairs. Floor equipment may alter use of table.

ELECTRICAL POWER: ___ I do require electrical power ___ I do not require electrical power

(Extension cords must be provided by each individual exhibitor) Please contact Shirley Goggin at 207-445-2260 for further assistance

On Friday evening, September 21st, we will have a Lobster Bake Dinner. Exhibitors and their guests are welcome to attend this dinner at a cost of $75 per person. Please complete the following (if not participating, please put zero):

Friday (9/21) Lobster Bake Dinner - # of persons_____($75 per person)

Exhibit Fee ($1,250 per table) $ _____

9/21/17 Dinner Fee (@ $75 pp) $ _____

Total Amount Due $ _____

Make checks payable to:

Downeast Ophthalmology Symposium
Tax ID # 010363625

Return Completed Form with Payment to:
Downeast Ophthalmology Symposium
P.O. Box 190, Manchester, ME 04351

No registrations will be accepted without payment. Payment by check is preferred. Cancellations prior to August 15, 2018 will be subject to a $250.00 administrative fee. No refunds of exhibit fees will be granted after August 15, 2018.

Please charge my: ☐ **Visa** ☐ **MasterCard**

Card #:_____ CCV:_____ **Exp:**_____

Signature: _____

Printed Name: _____

Address Associated w/Card:_____

Please contact Shirley Goggin, 207-445-2260 or sgoggin@mainemed.com with any questions or concerns.