



**THE 22ND ANNUAL
DOWNEAST
OPHTHALMOLOGY SYMPOSIUM**

SEPTEMBER 29 - OCTOBER 1, 2023
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. Guest is for Lobster Bake

Name/Address _____

E-Mail _____ Tel _____ Guest Name _____

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!!!

Registrations will be numbered as they come in with payment in the event space availability is issue.

EXHIBITOR REQUIREMENTS

EXHIBIT FEE: \$1,500 (PER TABLE/SPACE) Tables 6' x 30" with skirting, chairs. Floor equipment may alter use of table.
Multiple tables may be purchased by one company. Two representatives per table (speak to Shirley if you have other needs).

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 questions/assistance regarding space.

Exhibit Fee (\$1,500 per table)	\$ _____
Total Amount Due	\$ _____
<i>Make checks payable to:</i>	
Downeast Ophthalmology Symposium	
Tax ID # 01-0363625	
<i>Return Completed Form with Payment to:</i>	
Downeast Ophthalmology Symposium	
P.O. Box 190, Manchester, ME 04351	
sgoggin@mainemed.com	

No registrations will be accepted without payment. Payment by check is preferred. Cancellations prior to September 1, 2023 will be subject to a \$250.00 administrative fee. No refunds of exhibit fees will be granted after September 1, 2023.

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.