EXHIBITOR APPLICATION

Closure Course
March 3-4, 2018

Hampton Inn Tropicana – Las Vegas, Nevada

Company Name ______________________________

Name of Administrative Contact ______________________________

Company Address ______________________________

City ______________ State ______________ Zip ______________

Telephone ______________ Fax ______________ Cell ______________

Email ______________ Web Address ______________

(All meeting information will be sent to this address unless otherwise indicated)

Please email Brooke Kimberlin (bkimberlin@mohssurgery.org) your company logo and description of your company's products and services in 75 words or less.

On-Site Representative Names

(Two or four badges are included with each exhibit option – refer to page 4. Additional person charge: $50 each.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

We agree to abide by the exhibit specifications outlined by the ASMS and to all conditions under which the exhibit area is leased to the ASMS by the Hampton Inn Tropicana. Said exhibit specifications become a part of this contract.

Signature ______________________________

◯ **Exhibitor** $1,250

Total Payment

Please make checks payable to AMERICAN SOCIETY FOR MOHS SURGERY

(Fed. Tax ID 33-0445634)

For credit card payment, please complete the following information: Total: ______________

◯ Visa ◯ MC ◯ AMEX ◯ Discover Card # ______________

Expiration Date ______________ Verification Code (3-4 digit) ______________

Authorized Signer/Cardholder ______________________________