EXHIBITOR APPLICATION

Closure Course
February 2-3, 2019
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** $1,500

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 _____