

ASCRS Exhibiting Company

Exhibiting Company: _____
Address: _____
Contact name: _____
Position: _____
Phone: _____
Mobile phone: _____
Fax: _____
E-mail: _____

3rd party company

Company name: _____
Address: _____
Contact name: _____
Position: _____
Phone: _____
Mobile phone: _____
Fax: _____
E-mail: _____

Meeting Logistics

Date and time of the event: _____
Site registration opens: _____
Reception time: _____
Program time: _____
Will transportation to the event site be offered? * YES NO
Transportation start time: _____

**Please note, transportation may not be provided to and from the convention center location.*

Event title and description _____

Is the 3rd party company or one of its affiliates exhibiting at ASCRS? YES NO

Is this a CME function? YES NO

If yes, who is the accrediting body: _____

Expected attendance: _____
Physicians and optometrists _____
Administrators _____
Technicians _____
Nurses _____

Signatures

Exhibiting company _____

3rd party company _____

<p>INTERNAL USE ONLY</p> <p>Approval: _____</p> <p>Date: _____</p>
