3rd party Authorization Form

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 _____

INTERNAL USE ONLY
Approval:
Date: