

Washington State Medical Association
2009 Annual Meeting --- October 2 – October 4
EXHIBITOR/CONTRIBUTION APPLICATION

Davenport Hotel, Spokane, Washington

DISPLAY DAYS: 7:00AM Friday, October 2, 2009 to 5:00PM Saturday, October 3, 2009

● **COMPANY NAME:** _____

Exhibit Manager: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Fax: _____ E-mail: _____

Name of Company as you would like to be published in the program:

Name(s) of company representative(s) that will be staffing the booth:

• _____ • _____

Name of firm(s) you would prefer NOT to be located next to, or across from:

• _____ • _____

Requested by: _____

(Signature)

(Title)

Signature signifies company representative has read and agrees to abide by all WSMA policies regarding exhibit space and contributions including those adopted by WSMA & ACCME pertaining to the financial support of CME activities.

● **EXHIBIT BOOTH - \$1250.00** Yes, sign my company up for an exhibit booth _____

** If your company has not exhibited with us before, please describe the nature of your exhibit on a supplemental sheet & list the major conventions where the exhibit has appeared.*

** The Exhibit Practices & Regulations on the reverse side of this application are part of this agreement.*

Cancellations received on or after July 24, 2009 will be charged a \$500.00 service fee. No Refunds for cancellations received after September 4, 2009.

For information on non-profit booth space, call Patti Smith at the Washington State Medical Association, 206.441.9762.

● **EVENT CONTRIBUTOR**

President's Dinner & New President's Reception-Friday evening, October 2 _____

(minimum amount \$2,500)

Fri., Oct. 2, AM Exhibit Hall Coffee Break _____ Fri., Oct. 2, PM Exhibit Hall Coffee Break _____

(minimum amount \$1,000)

(minimum amount \$1,000)

Sat., Oct. 3, AM Exhibit Hall Coffee Break _____ Sat., Oct. 3, PM Exhibit Hall Coffee Break _____

(minimum amount \$1,000)

(minimum amount \$1,000)

Unrestricted Educational Grant _____

Payment in full must accompany this form.

Check enclosed (payable to WSMA) _____ MasterCard _____ Visa _____

Card # _____ Expiration Date _____

Name on Card _____ Signature _____

FOR OFFICIAL OFFICE USE ONLY

Date Rec'd: _____ Amt: _____ Ck: _____

Washington State Medical Association
2033 Sixth Ave., Suite 1100, Seattle, WA 98121
Tel: (206) 441.9762 Fax: (206) 441.5863
TAX ID #91-0462170