

WASHINGTON ACADEMY OF EYE PHYSICIANS & SURGEONS
2017 ANNUAL MEETING

MARCH 31, 2017
WASHINGTON STATE CONVENTION CENTER, SEATTLE, WASHINGTON

EXHIBITOR AGREEMENT

COMPANY NAME _____

PRIMARY CONTACT _____ TITLE _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE _____ FAX _____ E-MAIL _____

PRIMARY REPRESENTATIVE STAFFING YOUR BOOTH (This information will be published and distributed to attendees)

NAME _____ TITLE _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE _____ FAX _____ E-MAIL _____

PRODUCT/ SERVICE TO BE DISPLAYED: _____

*** PLEASE ATTACH A 50 WORD DESCRIPTION OF YOUR COMPANY TO BE INCLUDED IN THE E-SYLLABUS FOR THE MEETING.**

NAMES OF OTHER REPRESENTATIVES STAFFING YOUR BOOTH

All exhibitor representatives must be registered. *Two registrations are included with your exhibitor agreement.*
Additional rep packages are \$150 per person.

1) _____ 2) _____

3) _____ 4) _____

PLEASE INDICATE COMPANIES YOU DESIRE **NOT** TO BE LOCATED ADJACENT TO (I.E. COMPETITOR):

1) _____ 2) _____

THE SIGNATURE BELOW SIGNIFIES THAT THE COMPANY CONTACT HAS READ AND AGREES TO ABIDE BY ALL EXHIBIT PRACTICES AND REGULATIONS.

Signature _____ **Title** _____

NOTE: Booth location will be assigned based on booth category and in the order your booth was reserved and paid for. You will be notified of your space assignment on or before March 10, 2017. Save money by booking and paying for your booth early!

	Until 2/1/17	After 2/1/17
<input type="checkbox"/> PREMIUM BOOTH (8' X 10' BOOTH WITH PIPE AND DRAPE)	\$2950.00	\$3050.00
<input type="checkbox"/> STANDARD BOOTH (6' X 2' TABLE TOP)	\$2150.00	\$2250.00
<input type="checkbox"/> TICKET FOR ADDITIONAL REPRESENTATIVE(S)	# OF REPS _____ @ \$ 150.00 EA	_____
	TOTAL AMOUNT ENCLOSED:	_____

Note: All commercial representatives present at the WAEPS meeting must be registered as part of an exhibitor booth. No exceptions.

Cancellations received by 5 p.m. PST, March 1, 2017 will be charged a \$250 service fee. No refunds for cancellations received after March 1, 2017.

CHECK ENCLOSED CREDIT CARD: VISA M/C AMEX # _____

Name on Card _____ CVC Code _____ Exp. Date _____

Billing Address _____

City/State/Zip _____ Phone number of card holder: _____

PLEASE RETURN THIS FORM AND YOUR CHECK, MADE PAYABLE TO:

WAEPS, ATTN: Debra Alderman, 2001 Sixth Ave, Suite 2700, Seattle, WA 98121. If paying by credit card you may fax to 206-441-5863. Tax ID #91-0994722. Contact Debra with any questions: debra@wsma.org 206-956-3650