

CORPORATE SUPPORT - EXHIBIT RESERVATION FORM

The information in this section will be included in registrant packets on-site

Company Name: _____

Street Address: _____

City, State, ZIP: _____

Contact Person Name and Address: _____

Telephone: () _____ Fax number: () _____

Email: _____

Exhibit Opportunities:

One 6' Exhibit Table @ \$750

Sponsorship Opportunities:

Sponsorship packages do not include exhibit space. Exhibit space may be purchased at a discounted rate with any sponsorship package

Continental Breakfast

Exclusive Sponsor, 30% off exhibit space (\$525)

\$1,300

AM and PM Break

Exclusive Sponsor, 20% off exhibit space (\$600)

\$600

Lunch

Exclusive Sponsor, 40% off exhibit space (\$450)

\$3,200

Council Dinner (October 15th)

Exclusive Sponsor, 30% off exhibit space (\$525)

(Company representative welcome to attend)

\$2,000

**UAP 2009 Annual Scientific Meeting
Exhibitor Registration Form**

We would like to purchase exhibit space only (\$750) for October 16, 2010

We would like to purchase a Sponsorship Package only (\$600- \$3,200)

Please specify package _____ \$ _____

We would like to purchase exhibit space and a sponsorship package

Please specify package _____ \$ _____ Exhibit space \$ _____

Company Name: _____

Please list the names of representatives attending for name badges (*Attendance for two company representatives is included in the registration fee. Additional representatives may attend at \$75 each*)

Exhibit Space: 6-foot exhibit table – electricity included if indicated below.

Electrical Requirements:

We do not require electricity We require a standard electrical outlet- \$25

TOTAL REGISTRATION FEES: \$ _____

If possible, please do not place our exhibit next to the following companies:

We understand and agree to follow the policies of the **STANDARDS FOR COMMERCIAL SUPPORT OF CONTINUING MEDICAL EDUCATION** in support of the UAP Annual Scientific Meeting.

Authorized Signature _____ Date _____ Total Enclosed _____

Credit Card type (Visa, MC, Discover) _____ Credit Card Number _____ Ex. Date _____

UAP Tax ID# is 23-6444732

Make checks payable to “Urological Association of PA”
Please return this form before September 17, 2010 to:
MaryTherese Gallagher, UAP Meeting Manager
777 East Park Drive, PO Box 8820, Harrisburg, PA 17105-8820
Fax- (717) 558-7841
All exhibit fees must be paid by Friday, October 1, 2010

Questions? Call MaryTherese Gallagher at 717-909-2685 or email mgallagher@pamedsoc.org

Interoffice Use Only: Date received: _____ Amount pd/due _____ Check # _____ Table # _____