

**WASHINGTON CHAPTER
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**

SUMMIT TO SOUND - NORTHWEST EMERGENCY MEDICINE ASSEMBLY | MAY 17-18, 2012

EXHIBITOR AGREEMENT

COMPANY NAME _____
PRIMARY CONTACT _____ TITLE _____
ADDRESS _____
CITY/STATE/ZIP _____
TELEPHONE _____ FAX _____ E-MAIL _____
COMPANY WEBSITE _____

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

NAME _____ TITLE _____
ADDRESS _____
CITY/STATE/ZIP _____
TELEPHONE _____ FAX _____ E-MAIL _____

REPRESENTATIVES STAFFING YOUR BOOTH

1) _____ 2) _____
3) _____ 4) _____

PRODUCT/ SERVICE TO BE DISPLAYED: _____

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

1) _____ 2) _____

THE SIGNATURE BELOW SIGNIFIES THAT THE COMPANY REPRESENTATIVE HAS READ AND AGREES TO ABIDE BY ALL WA/ACEP EXHIBIT PRACTICES AND REGULATIONS (SEE ENCLOSED)

Signature _____ **Title** _____

- | | |
|--|---|
| <input type="checkbox"/> SPONSORSHIP OPPORTUNITY (ATTACHED FORM) | SPONSORSHIP AMOUNT _____ |
| <input type="checkbox"/> EXHIBITION BOOTH SPACE (PRIOR TO MAR 26, 2012)
Includes ticket packages for two representatives | # OF BOOTHS _____ @ \$ 1250.00 EA _____ |
| <input type="checkbox"/> EXHIBITION BOOTH SPACE (AFTER MAR 26, 2012)
Includes ticket packages for two representatives | # OF BOOTHS _____ @ \$ 1350.00 EA _____ |
| <input type="checkbox"/> TICKET PACKAGE FOR ADD'L REPRESENTATIVES | # OF REPS _____ @ \$ 150.00 EA _____ |

TOTAL AMOUNT ENCLOSED _____

CHECK ENCLOSED CREDIT CARD PAYMENT: VISA M/C

Credit Card # _____ Expiration Date ___/___

Name on Card _____

Signature _____

Billing Address _____

City _____ State _____ Zip _____

RETURN THIS FORM WITH PAYMENT TO WA/ACEP (TAX ID #91-0984720)

WA/ACEP, 2033 Sixth Ave, Suite 1100, Seattle, WA 98121. If paying by Credit Card you may fax to 206-441-5863