University of Florida College of

**Conference**

Date | Location| City

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Exhibitor Information** | | | | | | | | | | | | | |
| Company: | | |  | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | |
| City: |  | | | | | | | State: |  | | | Zip: |  |
| Contact Person: | | | | |  | | | | | | | | |
| Telephone: | | | |  | | | | | | | | Fax: |  |
| Representatives Attending: | | | | | | Name: |  | | | Email: |  | | |
| (include name, and email) | | | | | | Name: |  | | | Email: |  | | |
|  | | | | | | Name: |  | | | Email: |  | | |
|  | | | | | | | | | | | | | |
| **Fees** | | | | | | | | | | | | | |
| Please check the box with your level of participation:  $ XXX Entire Program  $ XXX Day/Month  Each exhibit space includes:   * One 6 foot table * Electrical services  Yes  No * Maximum of 2 representatives per table | | | | | | | | | | | | | |
| **Payment Information** | | | | | | | | | | | | | |
| Please check the box with your choice of payment:  Payment made online (Website)  Payment enclosed  Check mailed on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Checks should be made payable to: **University of Florida** (tax ID # 59-6002052) * Send check to: University of Florida CME Office, PO Box 100233, Gainesville FL 32610 | | | | | | | | | | | | | |

By signing below, exhibitors agree to hold the University of Florida harmless from and against any and all claims and damages arising out of exhibitors’ negligence or willful misconduct as a result of exhibitors exhibiting at the Conference date, in city, Florida. Exhibitors also agree to abide by policies and regulations of the venue, the hotel

|  |  |
| --- | --- |
|  |  |
| Authorized Signature | Date |
|  |  |
| Printed Name | Title |

**Send completed form to CONTACT:** [**contact**](mailto:Rayven.g@ufl.edu) **email**