



# THE 7TH ANNUAL DOWNEAST OPHTHALMOLOGY SYMPOSIUM

SEPTEMBER 19-21, 2008  
HARBORSIDE HOTEL AND MARINA, BAR HARBOR, MAINE

## EXHIBITOR REGISTRATION

Complete the information below and return form with full payment - Please print

Company Name \_\_\_\_\_ Web Site \_\_\_\_\_  
*Company name must be listed exactly as you wish it to appear in any official publications*

Company Address \_\_\_\_\_

Contact Person \_\_\_\_\_ Tel \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

### Representative(s) Attending Conference

*Information below will be used for name badges & attendance lists; if you plan to bring a guest, there is an additional charge. See below.*

Name/Address \_\_\_\_\_

E-Mail \_\_\_\_\_ Tel \_\_\_\_\_ Guest Name \_\_\_\_\_

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Name/Address \_\_\_\_\_

E-Mail \_\_\_\_\_ Tel \_\_\_\_\_ Guest Name \_\_\_\_\_

***SPACE IS LIMITED - RESERVE NOW - DON'T MISS OUT!!!***

### EXHIBITOR REQUIREMENTS

**EXHIBIT FEE:** \$1,000 Tables 6' x 30" with skirting, chairs.

**ELECTRICAL POWER :**    \_\_\_ I **do** require electrical power    \_\_\_ I **do not** require electrical power  
*(Extension cords must be provided by each individual exhibitor) Please contact Shirley Goggin at 207-445-2260 for further assistance*

Each exhibiting company will be allowed up to 2 complimentary meal tickets for the Saturday Evening Lobster Bake. Companies who have more than two representatives attending the conference, or who have guests accompanying their representatives, are asked to pay the \$75 per person guest fee for the additional representatives and/or guests who wish to participate in the meal functions. Please complete the following so that we may keep an accurate count for meals:

Friday Harbor Cruise - # of persons \_\_\_\_\_

Friday Lobster Bake - # of persons \_\_\_\_\_

No registrations will be accepted without payment. Cancellations prior to September 3, 2008 will be subject to a \$50.00 administrative fee. No refunds of exhibit fees will be granted after September 3, 2008.

Exhibit Fee. . . . .	\$ _____
<b>Additional Guest Fees</b> (@ \$75 pp) . . . . .	\$ _____
<b>Total Amount Due.</b> . . . . .	\$ _____
Make checks payable to:	
Downeast Ophthalmology Symposium	
Tax ID # 010363625	

Please charge my:     Visa     MasterCard

Card #: \_\_\_\_\_ Exp: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

\* Bank fees for processing credit card orders will be passed on to exhibit company. Checks preferred.

**Return Completed Form with Payment to:**  
Downeast Ophthalmology Symposium  
P.O. Box 190, Manchester, ME 04351

Please contact Shirley Goggin, 207-445-2260 or [sgoggin@mainemed.com](mailto:sgoggin@mainemed.com) with any questions or concerns.