



EXHIBITOR PERSONNEL REGISTRATION FORM

Please return this form NO LATER THAN September 30, 2010. Additional registrations over the 3 badge allotment will be assessed a \$100 per badge charge, payable before or at the time of registration. Refunds will not be issued for unclaimed badges. *Additional badges over the allotment will be charged \$100 per badge.*

Return to: **Northeastern Society of Plastic Surgeons**
Attn: Jennifer Gecawicz
Fax: 978-524-0498 or jgecawicz@prri.com

Name of Exhibiting Company:

Registrant #1: The official in charge of the booth(s) on-site will be:

Name: _____

Phone: _____ Fax: _____ Email: _____

Registrant #2 & #3: Three complimentary registrations are included in your exhibit package. Please list the remaining 2 registrants other than the on-site official contact listed above.

Additional exhibit representatives at \$100 per representative:

Please charge my:   

Card #: _____ Security Code _____ Exp _____

Signature: _____

- Please check if credit card billing address is same as contact information at the top of the form.
- If billing address is not the same please enter below.

Company Name: _____

Street Address: _____

City/State/Postal Code/Country: _____

Exhibitor certifies that the named person(s) meet your eligibility qualifications. I further understand that badges are not to be issued to representatives of leasing companies, financial institutions, publishers, suppliers, vendors, or others who wish to gain admittance for the purpose of making contacts other than in our exhibit. Exhibitors may not register any person eligible for registration at General Registration. All people registered under your company name must be employees of your company. Should anyone request a different company or organization name on their badge they will be asked to pay the full attendee fee for that category. i.e. physician, distributor, non exhibiting industry. Should anyone from your company request CME credits, they cannot register as an exhibitor, but must register in the appropriate category. i.e. physician, nurse, physician's assistant.

Signature: _____ Date: _____