

THE AMERICAN SOCIETY FOR COLPOSCOPY AND CERVICAL PATHOLOGY
APPLICATION FOR TABLETOP EXHIBIT SPACE

We, the undersigned, hereby make application for exhibit space at the following postgraduate course(s):

Comprehensive Colposcopy

- Oct. 18 – 21, 2007 in Nashville, TN
- April 17 - 20, 2008 in San Antonio, TX
- Aug. 7 - 10, 2008 in San Francisco, CA

Advanced Colposcopy

- Dec. 6 - 9, 2007 in Coronado, CA

High Resolution Anoscopy

- Aug. 7-19, 2008 in San Francisco, CA

Specific course information including hotel name and address can be found on the website:

www.asccp.org/meetings.shtml.

We understand that tabletop exhibit assignments will be made on a first-come, first-served basis, and only after receipt of payment in the amount of **\$1200.00** per course. In the case of cancellation, a refund of **\$1100.00** will be possible, but only if a written cancellation notice is received 30 days prior to the course start.

Products or services to be displayed:

One month prior to each course that you have elected to attend, you will be contacted for the names of your representatives and any special needs. Shipping instructions will be provided at that time.

If willing to guarantee equipment as part of the exhibit at each course, fees will be reduced to **\$3500 per annum**. Companies must attend all three *Comprehensive Colposcopy* courses and have on display either: 3 Colposcopes, 1 LEEP unit & 1 cryo unit or 4 LEEP units or 3 Infrared coagulators (HRA) or similar combination thereof.

Sign me up to bring equipment and attend all five courses:

_____ YES _____ NO

Total Amount Enclosed: \$ _____

We will bring the following equipment to the *Comprehensive Colposcopy* courses:

I have read and agree to adhere to the ASCCP codes and regulations as outlined in the General Exhibit Information form.

Signature

Company Name: _____

Address: _____

City/State/Zip Code: _____

Telephone: (_____) _____ Fax: (_____) _____

Email Address _____

Authorized By: _____ Title _____

Signature: _____ Date _____

Method of Payment: Check Visa MC Am Exp Card CVS Code _____

Credit Card Number _____ Expiration Date _____

Name as it appears on credit card _____ Signature: _____

ASCCP Authorization _____ Date: _____

Please mail this form along with payment to: Lindsay Hicks - ASCCP - 152 W Washington Street - Hagerstown, MD 21740
Telephone No. (800) 787-7227 - (301) 733-3640 - Fax No. (301) 733-5775 – www.asccp.org - lhicks@asccp.org