1. Company Information (As It Will Appear on Website & Print Materials):

Company Name:____
CompanyWebsite:____
Address:____
City:____________________ State:________ Zip Code:__________ Country:__________
Main Phone:________________________ Main Fax:________________________

2. Primary & Secondary Contact Person:

Primary Contact Name:____________________ Primary Title:____________________
Primary Telephone:____________________ Primary Email:____________________
Secondary Contact Name:____________________ Secondary Title:____________________
Secondary Telephone:____________________ Secondary Email:____________________

3. Booth Fees:

o 10’x 10’ $4,000
o 10’x 20’ $8,000
o 10’x 30’ $12,000

4. Booth Package Options:

o 10’x 10’ with Pre-Conference Workshop (30 minute) $7,000
o 10’x 10’ with Pre-Conference Workshop (1 hour) $9,000
o 10’x 20’ with Pre-Conference Workshop (30 minute) $11,000
o 10’x 20’ with Pre-Conference Workshop (1 hour) $13,000

5. Costs

Additional Support Level:________________
Total Due:____________________

6. Exhibit Location Preferences

1st:________ 2nd:________ 3rd:________ 4th:________

Preference will be based on the date your contract and payment are received by the DPA, membership and support level.

Please try to place my booth next to/near______________________________
We prefer not to be placed next to/near______________________________

o I would like to request one six foot draped table & two chairs.

7. Method of Payment

A 50% deposit is due with signed application to reserve space. Full payment is due by August 1, 2014.

o Credit Card o Check o Electronic Wire (Be sure to include $50 wiring fee.)

If you would like to pay by credit card, please complete the following information and fax (317.816.1633) or email (info@digitalpathologyassociation.org) the completed form to the DPA Executive Office.

Credit Card Type: o AMEX o Mastercard o VISA
Name (As It Appears On Card):______________________________
Billing Address:____
City:____________________ State:________ Zip Code:__________ Country:__________

Credit Card Number:____
Expiration Date:_________Verification Digits:_______ *(3-Digit # On Back of Card, or 4-Digit # On Front of AMEX)*

By signing this form, I hereby authorize the Digital Pathology Association to charge a 50% deposit immediately and the remaining balance on August 1, 2014.

o Payment in Full o 50% Deposit - Please charge the balance due on August 1, 2014

o We agree to abide by the Pathology Visions Terms and Conditions as found on page 8 of this document.

Authorized Signature:____

OFFICE USE ONLY: Booth #:______________Date Received:_____________ Received By:________________