REGISTRATION FORM

1. COMPANY INFORMATION (AS IT WILL APPEAR IN CONFERENCE MATERIALS)

Name: _____

Website: _____

Address: _____

City: _____ State: _____ Postal Code: _____ Country: _____

Main Phone: _____

2. PRIMARY AND SECONDARY CONTACT PERSON

Primary Name: _____ Secondary Name: _____

Primary Telephone: _____ Secondary Telephone: _____

Primary Title: _____ Secondary Title: _____

Primary Email: _____ Secondary Email: _____

3. BOOTH FEES *Company/organization group membership levels qualify for DPA member booth fees.*

- ○ 10′×10′ DPA Member: $5,000
- ○ 10′×20′ DPA Member: $10,000
- ○ 10′×10′ Non-Member: $7,000
- ○ 10′×20′ Non-Member: $14,000

If both parties sharing an Exhibitor Booth are DPA GROUP MEMBERS, the additional cost above the base rate for the Exhibitor Booth is $2,500.
If an Exhibitor Booth is being shared and the sharing entity is a NON-MEMBER, the additional cost above the base rate for the Exhibitor Booth is $3,500.

○ Member ○ Non-Member ☐ Sharing with: _____

4. BOOTH PREFERENCE

Booth Choices: **#1:** _____ **#2:** _____ **#3:** _____

We kindly request that our booth is **not** located next to: _____

*Booth assignments will be made after **July 1, 2023.***

5. SUPPORT OPPORTUNITIES (REFER TO PAGES 5 & 6 FOR MORE INFORMATION)

○ Support Level Exhibit Booth Only ○ Exhibitor Workshops None ○ On-Site Advertising None

6. METHOD OF PAYMENT

A 50% deposit is due with signed application to reserve space. Full payment is due by **June 30, 2023.**

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

If paying by check, please send to the DPA Executive Office at 370 Medical Drive, Suite A, Carmel, IN 46032.
*If paying by credit card, please email **(info@digitalpathologyassociation.org)** the completed form to the DPA Executive Office.*
Please note there will be a credit card fee of 3% for charges $5,000 and higher.

CREDIT CARD TYPE: ○ AMEX ○ Mastercard ○ VISA

Name *(as it appears on card)*: _____

Billing Address: _____

City: _____ State: _____ Postal Code: _____ Country: _____

CREDIT CARD NUMBER: _____

Expiration Date: _____ Email for payment receipt: _____

TOTAL AMOUNT DUE FOR BOOTH FEES AND SUPPORT OPPORTUNITIES: $ _____

○ Payment in Full ○ 50% Deposit *(Balance due on June 30, 2023)*

☐ We agree to abide by the Pathology Visions Terms and Conditions as found on page 10 of this document and understand the cancellation policy.

By signing this form, I hereby authorize the Digital Pathology Association to charge a 50% deposit immediately and the remaining balance on June 30, 2023.

AUTHORIZED SIGNATURE: _____