PHM2020

PEDIATRIC HOSPITAL MEDICINE
LAKE BUENA VISTA, FL / JULY 23-26, 2020

EXHIBITOR APPLICATION FORM

Exhibitor Information

Company Name	
Address	
City, State/Providence, Zip/Postal	
Company Website (mandatory)	
Exhibit Coordinator/Contact Person	
Title	
Phone	Fax
Email (mandatory)	

PLEASE NOTE: Registration forms that do not include an **email address** or **company website** will not be processed.

Product Category

- ☐ Billing, Coding and/or Documentation
- ☐ Consulting
- ☐ Device
- ☐ Diagnostics
- ☐ Education
- ☐ Hospital/Health System
- ☐ Hospitalist Management Company
- ☐ IT/Business Solutions
- ☐ Media/Publication(s)
- ☐ Nonprofit
- ☐ Pharmaceutical/Biotechnology
- ☐ Professional Society/Association
- ☐ Recruiting/Staffing Company
- ☐ Scribe Services
- ☐ Other:_____

Main Objective Select your primary objective at PHM2020:

- ☐ Advertisement and/or public relations
- ☐ Business to business networking
- ☐ Lead generation
- ☐ Product promotion
- ☐ Product sales
- ☐ Public education
- ☐ Recruitment
- ☐ Other:_____

Exhibit Price

- ☐ Exhibit cost $1,250

Cancellation Policy

Cancellations must be submitted in writing via fax or email. The postmark, fax or email date will determine your refund using the following schedule:

Full refund (less $250 administrative fee) ..... Prior to June 4, 2020

Full refund (less $500 administrative fee) ..... June 5- June 26, 2020

No Refund after June 27, 2020

Contract Agreement & Payment

We/I agree to abide by all requirements, restrictions, cancellation policies and obligations noted in the Exhibitor Contract, Rules and Regulations and all applicable legal requirements. This registration form becomes a binding agreement when accepted.

We/I agree to pay $_____, 100% of the charge for the exhibit space as a part of this registration and contract.

Contract Authorized Signature	
Title	Date / /

☐ Check enclosed **OR** Charge to the following: ☐ VISA ☐ MasterCard ☐ American Express

Cardholder's Name																CVV#				
Credit Card Number																Expiration Date	M	M	Y	Y
Total Charged	$			,			.	0	0	Cardholder's Signature										

Please direct any questions, comments or payments to:

Society of Hospital Medicine, Exhibits
P.O. Box 822898, Dept. 200E
Philadelphia, PA 19182-2898

exhibits@hospitalmedicine.org

800-843-3360

267-535-2911

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