The Arkansas Society of Otolaryngology – Head and Neck Surgery Conference

EXHIBITOR REGISTRATION

Company Name: _____

Contact Person: _____

Address: _____

_____

City: _____

State: _____**Zip:**_____

Email: _____

Main Attendee/Name Badge 1: _____

Additional Name Badges: _____

_____

Activities: *We will attend the Friday Night Reception*

_____ Number of Adults Attending

We will attend the Saturday Night Dinner
(2 representatives are included in the exhibit fee)

_____ Number of Adults Attending

Exhibit Needs: I will require electricity for my exhibit booth.
(Electrical & IT Services shall be contracted directly with the hotel)

Yes: _____ No: _____ Other:_____

Support: _____ I am interested in additional sponsorship opportunities. Please contact me with the information.

Please mail the exhibitor application and payment by September 1 to:

ATTN: Beth Seward/ Arkansas Society of Otolaryngology

c/o Department of Otolaryngology-HNS

University of Arkansas for Medical Sciences

4301 West Markham, #543

Little Rock, AR 72205

Make payments payable to ASO/HNS