

The Arkansas 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*

\_\_\_\_\_ 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**