

# **EXHIBITOR REGISTRATION FORM**

## **Exhibitor Information**

Title
Phone & Fax

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

#### \*If a Third Party is representing the above-named Exhibitor, please complete:

Representing Company Name & Full Address	Contact Person & Title

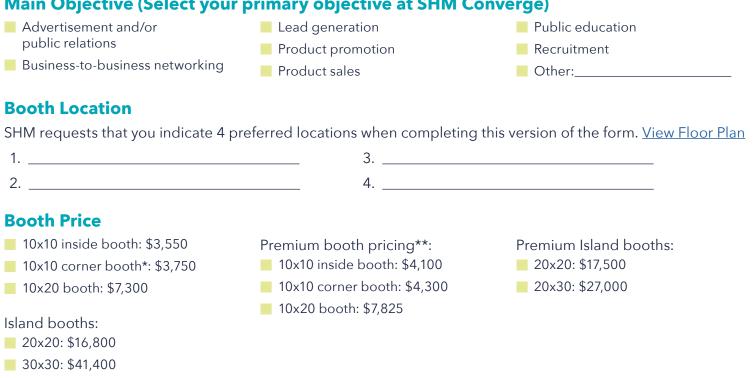
#### **Product Category (please select one)**

- Billing, Coding, and/or Documentation
- Consulting
- Device
- Diagnostics
- Education

- Hospital/Health System
- Hospital Management Company
- IT/Business Solutions
- Media/Publication(s)
- Non-Profit

- Pharmaceutical/Biotechnology
- Professional Society/Association
- Recruitment/Professional Staffing
- Scribe Services
- Other:\_\_\_

## Main Objective (Select your primary objective at SHM Converge)



\*Corner booth assignment is based on availability and not guaranteed. \*\*Premium booths are located in Premium Promenade and Converge Square on the Floor Plan.

## **Contract Agreement & Payment**

We/I agree to abide by all requirements, restrictions, cancellation policies, and obligations noted in the Partner Terms and Conditions and all applicable legal requirements. This registration form becomes a binding agreement once accepted. Once your application has been processed you will receive an email confirmation and invoice from Map Your Show.

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

Contract Authorizer Name	Contract Authorizer Signature
Title & Company	Date

## **Payment**

#### Check Enclosed

(payable to Society of Hospital Medicine). Please remit payment in U.S. Funds drawn on U.S. bank. All payments must be received and paid in full prior to being provided access to service kits, entry into the engagement arena, etc.

#### □ Charge credit card Please note, all credit card transactions will be subject to an additional 3.5% service fee.

All requested credit card payments will receive an invoice and/or be contacted to provide payment details via phone.



#### This form is to be used solely in the event that your company cannot register using the online form.

#### Please direct any questions, comments, or payments to:

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

bizdev@hospitalmedicine.org

800-843-3360 267-535-2911