Saturday, October 1, 2016
UCSD School of Medicine, La Jolla, CA

EXHIBITOR REGISTRATION FORM

Company: _____

Contact: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell / Alt Phone: _____

Email: _____

Website: _____

On-Site Company Representatives
List names exactly as they should appear on badges. Registration for the first two reps is included in the $1,500 exhibitor space fee. Additional reps must be registered for $550 each and can be listed on a separate sheet of paper.

Name: _____

Email: _____

Name: _____

Email: _____

PAYMENT INFORMATION:

❑ $1,500 per exhibit space ❑ Yes! I will need electrical

TOTAL: $_____

❑ Check payable to *"California Thoracic Society"* (Tax ID #80-0627724) ❑ VISA/MC/AMEX

Card#: _____ Exp: _____ Billing Zip Code: _____

Signature: _____

Print name as it appears on card: _____

There will be a 50% cancellation fee for cancellations received before Sept. 16, 2016 and no refunds thereafter.

RETURN EXHIBIT REGISTRATION FORM TO:
California Thoracic Society (CTS,) 575 Market Street, Suite 2125 San Francisco, CA 94105
Phone: 415-536-0287 / Fax: 415-764-4933 / Email: info@calthoracic.org