

Vendor Exhibit Reply Form

Title of Activity: 2 nd Annual Mammography Seminar				
Date: Saturday, October 5	, 2013 Location:		igh Memorial Medical Cei n, Pennsylvania	ıter
Medical Sales/Education Representative		Company/Supporter Attending		
Address		City	State	Zip
Phone	Fax		Email	
*Conemaugh Health System reso	erves the right to respec	etfully declin	e support from any vendor.	
Vendor Exhibit Fee:				
□ \$250 – includes one (1) registred credit), acknowledgement of supportable and two (2) chairs.				-
Please list the Name, Address	, and Phone Number	of represent	tative who will be attending	ŗ :
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Payment Enclosed: (Circle one) Check Master Card #:			Return Form and Pa Conemaugh Memorial Department of Continu	Medical Center
Exp Date:Signature:			1086 Franklin Street Johnstown, PA 15905	;
Tax ID #: 25-0965307			Phone: (814) 534-1164 Fax: (814) 534-1498	

1086 Franklin Street Johnstown, PA 15905-4398 814-534-9000 www.conemaugh.org