Conemaugh Health System

Vendor Exhibit Reply Form

Title of Activity: **2013 Fall Trauma Conference** – "*Taking Care of Business, a Blue Collar Approach*"

Date: 11/8/13 Location: Pasquerilla Conference Center, Johnstown, PA

_____ _____

Medical Sales/Education Representative Company/Supporter Attending

_____

Address City State Zip

_____ _____ _____

Phone Fax Email

**Conemaugh Health System reserves the right to respectfully decline support from any vendor.*

Vendor Exhibit Fee:

☐ **$250 –** includes one (1) registration to the seminar (includes meals, refreshments, conference material, and professional credit), acknowledgement of support announced and written in program materials, one (1) 6-foot exhibit space including table and two (2) chairs.

Please list the Name, Address, and Phone Number of representative who will be attending:

1. _____

Payment Enclosed:
(Circle one) Check Master Card Visa Discover
Card #:_____
Exp Date:_____
Signature:_____
Tax ID #: 25-0965307

Return Form and Payment to:
Conemaugh Memorial Medical Center
Department of Continuing Education
1086 Franklin Street
Johnstown, PA 15905
Phone: (814) 534-9782
Fax: (814) 534-1498