

Exhibitor Agreement

Collaborative Family Healthcare Association

A. Company Information. This information will appear in CFHA publications; print legibly or type.

Company Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

Website _____

B. Primary Contact. This person will be the primary point of communication and will be sent all information related to your participation.

Contact person & title _____

Contact person phone _____ Contact person fax _____

Contact person email _____

C. Exhibit Space. The CFHA Lounge will host vendor exhibits at the 2009 CFHA Conference, October 22-24, 2009, in San Diego, CA. Exhibit participation is limited on a first-come, first serve basis. Please select the appropriate option(s) below.

- CFHA Member Exhibit Space - \$800** **Non-Member Exhibit Space - \$1,000**
- \$50 Electrical outlet (optional) \$50 Electrical outlet (optional)

D. Advertising in CFHA Vendor Directory. Production details and deadlines will be sent to confirmed advertisers.

- Back Cover (full color) \$1,000 Inside Ad, full page (one color) \$500 Inside Ad, half page (one color) \$300 CFHA Slide Show (one slide) \$300

E. Vendor Directory. Please include brief information about your products and services to appear in the CFHA Vendor Directory.

G. Payment A minimum \$500 non-refundable deposit is due with signed agreement; your application may not be accepted until deposit is received. The balance is due no later than September 1, 2009. If the agreement is received on or after September 1, payment in full is required with signed agreement. An exhibitor will not be allowed to set-up or display unless fees are paid in full.

TOTAL AMOUNT DUE	\$	<p>Make all checks payable to "CFHA"</p> <p>The balance will be due on Sept 30, 2009 An invoice will be sent for Balance Due amount.</p> <p>Your credit card will be charged for the remainder unless other arrangements have been made with the CFHA.</p>
LESS NON-REFUNDABLE DEPOSIT * (\$500 minimum)	-- \$	
BALANCE DUE no later than September 30, 2009	\$	

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Cardholder's name (print legibly)	
VISA / MasterCard number	
Expiration date	Security code (3-digit number on back of card)
Cardholder's signature	

The Collaborative Family Healthcare Association is a 501c3 organization, federal tax ID# 13-3832381.

H. Vendor Acceptance.

By signing below, I/we agree to comply with the Terms and Conditions outlined on the CFHA Vendor Prospectus.

Company name (print)	
Contact person & title	
Signature	Date

Return completed agreement and payments (payable to "CFHA") to:

Collaborative Family Healthcare Association
c/o Steffani Blackstock, Conference Manager
ASCENT Meetings, P. O. Box 632167, Highlands Ranch, CO 80163-2167
Phone 720-940-4880 CFHA@ascentmeetings.com
www.CFHA.net

Fax 303-395-2609

Requests or Comments?