All exhibitors are provided with:

1. One (1) 6 ft. draped table, two chairs, one (1) wastepaper basket.
2. Electrical outlets will be available in the exhibit area. Additional extension cords/electrical strips are the responsibility of each exhibitor.
3. Listing of pre-registrants.
5. Complimentary admittance to scientific sessions.

Table top exhibit (1, 6’ table w/drape)
$800 for 1½ days Thursday April 30th – May 1st, 2020

ADA CERP® Continuing Education Recognition Program
ASDA is an ADA CERP Provider of Continuing Education
ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.
Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at www.ada.org/cerp.
APPLICATION/CONTRACT FOR CORPORATE EXHIBITOR

****Please type or print clearly****

Complete all sections and return with your full payment to the American Society of Dentist Anesthesiologists, Attn: Erin Baker, ASDA Executive Director, 956 S Bartlett Rd #119, Bartlett IL, 60103. Phone (630) 242-8940; Fax (331) 215-6109. Space cannot be reserved without full payment. No refunds or cancellations without 30 days written notice. Please contact Erin Baker, ASDA Executive Director, at (630) 242-8940 with any questions.

The exhibitor agrees to abide by all rules, requirements, restrictions and regulations designated by the American Society of Dentist Anesthesiologists and The Loews Philadelphia.

EXHIBITOR INFORMATION

Company Name __________________________________________________________
Street Address ___________________________________________________________
City ____________________________ State ____________ Zip _______________
Phone _______________________ Fax _____________________ E-mail __________
Contact Person __________________________________________________________
Submitted by ______________________________________________

PAYMENT OPTIONS

Check (make payable to American Society of Dentist Anesthesiologists) _________
Visa____  MasterCard _____  Amount $___________
Card Number ___________________________________________________________
Exp. Date ___________  3-digit CVV code: ______________
Signature ____________________________________________________________