

EXHIBIT SPACE APPLICATION AND CONTRACT

47th AAPM Annual Meeting • Exhibit Dates July 24 - 27, 2005 • Seattle, WA

Instructions

1. Please print or type all information requested.
2. Sign this copy and mail or fax with **FULL payment** to:
Lisa Rose Sullivan, AAPM, One Physics Ellipse, College Park, MD 20740-3846 or Fax 301-209-0862
3. Return by **March 2** for first consideration in space assignments, per the Exhibit Space Assignment Process posted in the 2005 Exhibitor Prospectus.
4. Booth assignments will be mailed **April 15**.

Space Selection	Booth No(s)	Booth Size	Number of Corners Requested <small>(For Inline Booths only)</small>	Total Amount
1 st	_____	_____ X _____	_____	\$ _____
2 nd	_____	_____ X _____	_____	\$ _____
3 rd	_____	_____ X _____	_____	\$ _____

Competitor Proximity

- | | |
|--|---|
| List any Exhibitors you wish to be near :
1. _____
2. _____
3. _____ | List any Exhibitors you do not wish to be near :
1. _____
2. _____
3. _____ |
|--|---|

Space Assignment Priority

Rank (1 - 4) beginning with most important criteria for space assignment:
 _____ Floor Location _____ Competitor Proximity _____ Associate Proximity _____ Corner Space

Product Category **IMPORTANT: Please check the appropriate boxes.**

Product Focus:

Medical Equipment
 Medical Imaging
 Pharmaceuticals
 Publishing
 Radiation Oncology
 Other

Product Line(s):

<input type="checkbox"/> Brachytherapy	<input type="checkbox"/> Lasers & Optics Manufacturer	<input type="checkbox"/> Shielding/Construction
<input type="checkbox"/> CT/MRI	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Technology Management
<input type="checkbox"/> Detectors/Dosimetry	<input type="checkbox"/> Patient Handling/Positioning	<input type="checkbox"/> Treatment Planning
<input type="checkbox"/> General Medical Physics	<input type="checkbox"/> Pharmaceutical Manufacturer	<input type="checkbox"/> Treatment Units
<input type="checkbox"/> Government Agency	<input type="checkbox"/> Professional Society	<input type="checkbox"/> University
<input type="checkbox"/> Imaging Film	<input type="checkbox"/> Quality Assurance	<input type="checkbox"/> X-ray/Radiographic
<input type="checkbox"/> Info Systems Management	<input type="checkbox"/> Simulators	<input type="checkbox"/> Ultrasound

Company _____ Date _____
(List as to be displayed in all printed materials)

If newly formed company, please list previous company name: _____

Contact Name (please print) _____

Mailing Address _____

City, State, Zip/Postal Code, Country _____

E-mail (required) _____ Tel _____ Fax _____

Check if address change from previous year

Completed by/Signature _____ Title _____

Payment: Please indicate payment type

MasterCard
 American Express
 Visa
 Check drawn on US bank, payable to AAPM

Credit Card Number _____
 Expiration Date _____
 Signature _____

TOTAL PAYMENT WITH CONTRACT: \$ _____

(Do not write below this line)

Date Received _____ Contract No _____ Corporate Affiliate Level _____

Points: Date _____ + Historical _____ + Bonus _____ = _____

Price of Space \$ _____ Amt. Enclosed \$ _____ Space Assigned _____