

EXHIBIT SPACE APPLICATION AND CONTRACT

43rd AAPM Annual Meeting • Exhibit Dates July 22 - 25, 2001 • Salt Lake City, Utah

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. Booth assignments will be mailed **April 13**.

Space Selection	Booth No(s)	Booth Size	Number of Corners Requested <i>(For Inline Booths only)</i>	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 Please check the appropriate boxes. This information will be used for the AAPM 2001 Buyers Guide that will be posted on the AAPM website (<http://www.aapm.org>)

Product Focus:

Medical Equipment
 Medical Imaging
 Pharmaceuticals
 Publishing
 Radiation Oncology
 Other

Product Line(s):

<input type="checkbox"/> Brachytherapy <input type="checkbox"/> CT/MRI <input type="checkbox"/> Detectors/Dosimetry <input type="checkbox"/> General Medical Physics <input type="checkbox"/> Government Agency <input type="checkbox"/> Imaging Film <input type="checkbox"/> Info Systems Management	<input type="checkbox"/> Lasers & Optics Manufacturer <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Patient Handling/Positioning <input type="checkbox"/> Pharmaceutical Manufacturer <input type="checkbox"/> Professional Society <input type="checkbox"/> Quality Assurance <input type="checkbox"/> Simulators	<input type="checkbox"/> Shielding/Construction <input type="checkbox"/> Technology Management <input type="checkbox"/> Treatment Planning <input type="checkbox"/> Treatment Units <input type="checkbox"/> University <input type="checkbox"/> X-ray/Radiographic <input type="checkbox"/> Ultrasound
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Company _____ Date _____
(List as to be displayed in all printed materials)

If newly formed company, please list previous company names:

Contact Name (please print) _____

Mailing Address _____

City, State, Zip/Postal Code, Country _____

Tel _____ Fax _____ E-mail _____

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 _____