INDUSTRY SATELLITE SYMPOSIUM APPLICATION

SCVS 47th Annual Symposium
March 16 - 20, 2019
Boca Raton Hotel | Boca Raton, Florida

Exact Title of Symposium _____ Name of Accrediting Organization _____

Supporting Company Name _____ Contact Name _____

Address _____ City _____ State _____ Zip _____ Country _____

Phone _____ Fax _____ Email _____

Brief Description of Meeting:

Target Audience: _____ **Expected Attendance:** _____

DAY/DATE/TIME OF MEETING

☐ **Monday, March 18th $12,000 (3 Concurrent)**
Lunch 12:45 pm - 2:00 pm

☐ **Tuesday, March 19th $10,000 (3 Concurrent)**
Breakfast 6:45 am - 8:00 am

Once space has been assigned and confirmed by SCVS you will be put in direct contact with a catering representative. Catering, special set fees, additional AV, electrical/ telecommunications, and labor are not included in the fee. Each Supporter is responsible for all charges to the facility. By signing below you are authorizing SCVS to charge the total fee indicated on this form to your credit card.

_____ _____
Signature Date

PAYMENT INFORMATION: All checks must be payable to the Society for Clinical Vascular Surgery (SCVS)
PLEASE REFER TP PAYMENT METHOD ON PG. 1. ***For your security, we cannot accept emailed credit card numbers. Please fax them to the secure fax line below.***

☐ Check amount enclosed: $_____

CREDIT CARD ☐ ☐ ☐ **Amount to be charged: $**_____

_____ _____ _____
Credit Card Number Expiration Date Security Code (3-4 numbers on front or back of card)

_____ _____
Name as it appears on credit card Cardholder's Signature

❑ **Secure Fax**: + 978.524.0461 **This form must be faxed if credit card number is showing. DO NOT EMAIL.**
❑ Please check if credit card billing address is same as contact information at the top of the form.
❑ If billing address is different please enter it below.

_____
Company Name

_____
Street Address

_____
City/State/Postal Code /Country

Complete and return to:
SCVS
500 Cummings Center, Suite 4400
Beverly, MA 01915 USA
978-927-8330 Fax: 978-524-0461