Exhibitor Application Form

We understand that space will be rented at the following rates:

Exhibit Type:	Rate:
Nonprofit Organization	$500
For-profit Organization	$1000

What's included:

- 6 foot draped table
- one (1) complimentary full conference registration
- listing on *ABM* website
- recognition in Meeting Syllabus and On-Site Signage
- recognition on our Social Media Channels (reach over 40,000 *ABM* followers)

We understand that all space must be paid for in full by **September 18, 2019**. If assigned space is not paid for in full by the specified date, it may be reassigned to another exhibitor at the option of the Academy of Breastfeeding Medicine.

Exhibit Type ____________________ Rate ____________________

List companies that you would prefer to not be near.

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(Please print or type.)

By checking this box (mandatory), the Exhibitor confirms that it supports WHO International Code of Marketing Breastmilk Substitutes and any related subsequent WHO resolutions, and is in compliance. Acceptance of Exhibit does not constitute *ABM's* endorsement of the organization, its product, or service.

FOR ABM USE ONLY (HC)

Booth number(s) assigned ____________________

Total cost $ ____________________

Amount paid $ ____________________

Accepted: ABM, by ____________________________________

Company Information

This representative will be contacted for details and for future related mailings. Please print or type.

Firm name ______________________________________

(Exactly as you wish it to appear on the exhibit sign.)

Street address ______________________________________

City, state, ZIP ______________________________________

Phone (____) ______________________________________

Fax (____) ______________________________________

E-mail ______________________________________

Website ______________________________________

Name ______________________________________
(first) (last)

Title ______________________________________

READ BEFORE SIGNING: Exhibitor's signature on this contract indicates acceptance of the terms and conditions provided with this contract and is an agreement to pay the total amount due. The person signing this contract on behalf of the exhibitor has the authority to do so and is responsible for employees' adherence to the terms and conditions.

Signature ______________________________________

Billing Information

This contract will be addressed to the signer (or designee indicated below, if different from above). **Please complete this section or notate "Same" if the same as above.**

Name ______________________________________
(first) (last)

Title ______________________________________

Firm name ______________________________________

Address ______________________________________
(if different from above)

City, state, ZIP ______________________________________

Phone (____) ________________ Fax (____) ________________

E-mail ______________________________________

Please complete all three steps.

1. Fax to 888.374.7259 or scan to rpfrey@bfmed.org.
2. Make a copy of this form for your records.
3. Return the original, with payment, to:

The Academy of Breastfeeding Medicine
8735 W. Higgins Rd., STE 200
Chicago, IL 60631

*Make checks payable to The Academy of Breastfeeding Medicine.

Contact Rob Frey at 847.375.6470 or rpfrey@bfmed.org with any questions.

Payment Information

cc#______________________exp__________$ ________

Check # ______________ $ ______________

Date of check or processing _____

Check #______________$ ______________

Date of check or processing ____________