

EXHIBITOR PROSPECTUS

NCCN 4th Annual Congress:

Hematologic Malignancies™



EXHIBIT SPACE APPLICATION AND CONTRACT

INSTRUCTIONS

1. Apply for exhibit space by completing this form and submitting it with payment by **Friday, July 31, 2009**.
2. You will receive a confirmation letter and a registration packet including attendee registration forms.
3. You will receive a Service Kit with exhibit details four to six weeks before the event.

SEND COMPLETED APPLICATION TO:

Jennifer Tredwell

Senior Advertising Manager
NCCN
275 Commerce Dr., Suite 300
Ft. Washington, PA 19034
Phone – 215.690.0274
Fax – 215.690.0280
tredwell@nccn.org

FOR SUPPORT OPPORTUNITIES:

Lyn Fitzgerald

Director, Pharma/Biotech
NCCN
275 Commerce Dr., Suite 300
Ft. Washington, PA 19034
Phone – 215.690.0226
Fax – 215.690.0280
fitzgerald@nccn.org

EXHIBITOR INFORMATION (please type or print clearly)

Organization _____

Contact Name _____
(Name of person who will be responsible for your exhibit and to whom all future correspondence should be sent)

Title _____

Mailing Address _____

City _____ State/Province _____ Zip Code/Postal Code _____

Phone _____

E-mail (required for registration) _____

1st Complimentary Registrant Name: _____

E-mail _____

2nd Complimentary Registrant Name: _____

E-mail _____

PROMOTIONAL INFORMATION

Organization Name for Conference Materials (Use upper and lower case letters exactly as you want your organization's name to appear on conference materials and signage)

PAYMENT INFORMATION

NCCN 4th Annual Congress: Hematologic Malignancies™

- o \$10,000 (if reserved before July 31, 2009) - Tabletop only
- o \$1,500 Run-of-book, 4-color, full page Ad in the NCCN Exhibit Guide
- o Check enclosed
(Please make checks payable to: National Comprehensive Cancer Network and mail to:
NCCN, 275 Commerce Drive, Suite 300, Ft. Washington, PA 19034, Attn: Janice Tucker)
- o Credit Card: Visa/MasterCard/American Express

Cardholder's Name _____

Billing Address _____

City _____

State/Province _____ Zip/Postal Code _____

Card Number _____

Card Verification # _____ Exp. Date _____

NCCN may charge the credit card for the amount as indicated above.

Signature _____