



*The Future of HealthCare is ours to create!*

# Senior Health Fair

September 27, 2017 10am-2pm

Crowne Plaza Pittsburgh South, 164 Fort Couch Road, Pittsburgh, PA 15241

## Exhibitor Agreement

---

### Participant Information: \*please return by 9/22/2017

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Day of Event Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Additional Contact (if needed): Contact Person: \_\_\_\_\_

Day of Event Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Description of all products/services to be displayed and/or promoted at the fair:  
\_\_\_\_\_

Description of Donation for Optional Raffle: \_\_\_\_\_

We require electricity: Yes \_\_\_\_\_ No \_\_\_\_\_ # tables of needed: \_\_\_\_\_ # of chairs needed: \_\_\_\_\_

Additional needs: \_\_\_\_\_

**Pay with Check: (please make checks payable to (American HealthCare Group) Fee: \$100**

**Pay with Credit: Type: Visa, MC, American Express**

Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Name on Card & Security Code: \_\_\_\_\_

Billing Address for Credit Card: \_\_\_\_\_

### Sign & Return Agreement:

I, the undersigned, hereby make application for exhibit space at the event(s) listed above. I agree to be at the above listed event(s) at the above listed date(s) and time(s) or be charged a fee of \$75 unless I cancel the event 7 days prior.

Name (please print) Signature: \* \_\_\_\_\_

Position/Title: \_\_\_\_\_ Date: \_\_\_\_\_



*The Future of HealthCare is ours to create!*

Please send form to address below or Fax: 412-563-8319 Email: [cclipper@american-healthcare.net](mailto:cclipper@american-healthcare.net)