

EXHIBIT & SPONSORSHIP APPLICATION

The company name will appear in all IDA marketing pieces as shown below:

Company Name: _____

Address: _____

City _____ State _____ ZIP _____

Customer Service Phone: _____

Customer Service Email: _____

Website: _____

Product/Service: Laboratory Dental Supplies Drugs Toothbrushes Insurance Instruments Equipment

Other _____

The primary contact will receive all IDEAS24 communications leading up to the event:

Primary Contact Name: _____

Title: _____ Email: _____ Phone: _____

If available, these are our booth preferences, realizing that IDA may not be able to accommodate selections:

1: _____ 2: _____ 3: _____

If possible, please do not place our booth next to the following companies: _____

BOOTH RESERVATION:

BEFORE MARCH 29

STANDARD BOOTH: \$1,000 X # of booths: ___ = \$ _____

PREMIUM BOOTH: \$1,500 X # of booths: ___ = \$ _____

AFTER MARCH 29

STANDARD BOOTH: \$1,250 X # of booths: ___ = \$ _____

PREMIUM BOOTH: \$1,750 X # of booths: ___ = \$ _____

SPONSORSHIP AND ADVERTISING:

Items: _____

POWER FOR BOOTH: \$50 X # of booths: ___ = \$ _____

Total sponsorship/advertisements due: \$ _____

TOTAL COST = \$ _____

METHOD OF PAYMENT:

Check: (made payable to IDA) _____

Credit Card: MasterCard Visa AMEX Discover

Card Number: _____ Exp. Date: _____ CVV: _____

Cardholder Name: _____

Billing Address: _____

Cardholder Signature: _____

By signing below, client agrees to the Rules & Regulations as outlined on the ideas.iowadental.org website. Upon request, client agrees to provide proof of insurance 60 days prior to the conference. Applications will not be considered and space will not be reserved until payment is submitted in full.

Signature: _____

RETURN TO: Email form to info@iowadental.org and call 515.331.2298 for credit card payments, or mail form with payment information to IDA, 666 Grand Avenue, Suite 901, Des Moines, IA 50309. Please do not send credit card numbers via email.