



**APPLICATION for EXHIBIT SPACE**  
**The Facial Aesthetic Symposium - 2012**  
**March 28 – April 1, 2012**  
**Westin Buckhead, Atlanta, GA**  
PLEASE TYPE OR PRINT

Company \_\_\_\_\_ (as you wish it to appear on identification sign)

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_ Web Site \_\_\_\_\_

Indicate your display space choice #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ (Assigned on a first come-first served basis)  
Prime Space \$2250      Standard Space \$1850

Exhibitor Registrant(s)

Please note that you can have badges made for up to two (2) individuals without an additional fee.

(1) Name \_\_\_\_\_ Title \_\_\_\_\_

(2) Name \_\_\_\_\_ Title \_\_\_\_\_

You may register up to two (2) more representatives for \$175 each.

(3) Name \_\_\_\_\_ Title \_\_\_\_\_

(4) Name \_\_\_\_\_ Title \_\_\_\_\_

As an authorized representative of the company named above, I have read the rules and regulations outlined in the prospectus. I understand and agree to accept and abide by those rules and regulations adopted by FFAS for the conduct of the symposium. The acceptance of our application by the FFAS and the payment for rental charges constitute a contract. I understand that in the event the meeting is canceled due to Acts of God, Acts of Terrorism, or any kind of state or national emergency a partial refund will be made, less a prorated share of expenses actually incurred by FFAS in connection with the Symposium. Exhibitor shall accept such refund in full settlement of all loss or damage suffered by Exhibitor. I understand that there are no cancellations after February 1, 2012 and NO OTHER EXCEPTIONS WILL BE MADE, due to the rental and location of this event.

Print Manager's Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Full payment must accompany the application for space. No applications will be processed without full payment. Check or charge card information must accompany this form. Make check payable to FFAS. If paying by credit card, please indicate amount to be charged.

\_\_\_\_\_ Check      \_\_\_\_\_ Visa      \_\_\_\_\_ MasterCard      \_\_\_\_\_ American Express      \_\_\_\_\_ Discover

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_ Amount to be charged \$ \_\_\_\_\_

Print Card Holder's Name \_\_\_\_\_ Signature \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Address of Charge Card

**Make checks payable to:** FFAS or Foundation for Facial Aesthetic Surgery

7497 Poplar Pike

Germantown TN, 38138 (901) 756-5400 office; (901) 757-5543 fax