

**Mid-Atlantic Association of Community Health Centers**

**HERS! Health Empowerment and Resource Symposium**

**APPLICATION FORM**

Please type or print neatly: (this information is important for badge information and official exhibitors' list)

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Name of Contact: \_\_\_\_\_ Name of Representative On-Site: \_\_\_\_\_

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Sponsor/Company: \_\_\_\_\_

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Address: \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Email \_\_\_\_\_ Website: \_\_\_\_\_

PLEASE DESCRIBE DISPLAY: \_\_\_\_\_

Contact Person (for display and logo): \_\_\_\_\_

ELECTRICAL POWER (subject to availability)

\_\_\_\_\_ I would like to request electricity for my booth.

**PLEASE CHECK EXHIBIT/SPONSORSHIP LEVEL:**  
**(Contact MACHC to discuss additional sponsorship opportunities)**

**EXHIBITORS:**    \_\_\_ \$1,000.00                      \_\_\_ \$750.00                      \_\_\_ \$500.00                      \_\_\_ \$250.00

**SPONSORSHIP:**        \_\_\_ Demonstration Area                      \_\_\_ Giveaways/Prizes                      \_\_\_ Other (See attachment)

\_\_\_\_\_ I have enclosed a check made payable to the Mid-Atlantic Association of Community Health Centers.  
*(Payment due with submission of application)*

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Name of Responsible Party                      Signature of Responsible Party                      Date

**CANCELLATION/REFUND POLICY**

No refunds or cancellations will be permitted after receipt of application and contract by the Mid-Atlantic Association of Community Health Centers.

**PLEASE RETURN APPLICATION WITH PAYMENT ON OR BEFORE FRIDAY, MARCH 30, 2007.**

**Mid-Atlantic Association of Community Health Centers**  
**4483-B Forbes Boulevard, Suite B**  
**Lanham, MD 20706**  
**Attn: Deitra Bell**  
**301-577-0097, ext. 23, 301-577-4789 - fax**  
Email: [deitra.bell@machc.com](mailto:deitra.bell@machc.com)