

EMTC 2011

ORDER FORM FOR AN EXHIBITION STAND

European Medical Travel Conference 2011
from 27th to 29th of April, 2011 in Barcelona, Spain.

NAME:	FIRST NAME:	MR. <input type="checkbox"/> MS. <input type="checkbox"/>
TITLE:	COMPANY/INSTITUTION:	
STREET:	CITY:	
ZIP CODE:	COUNTRY:	
PHONE:	MOBILE:	
EMAIL:	VAT ID No. (compulsory for EU invoice):	

REGISTRATION FEE FOR STAND OWNERS/PARTICIPANTS

Full registration (incl. see below)*	<input type="checkbox"/>	170 €
Non-Profit Organisation	<input type="checkbox"/>	150 €
Student	<input type="checkbox"/>	70 €
Exhibitor Rate (no access to B2B or workshops, lectures), compulsory for additional stand personnel, see below. In case the stand personnel books for a full registration at reduced rate (normally 460 €) this section is not applicable.	<input type="checkbox"/>	70 €
Gala Dinner Ticket	<input type="checkbox"/>	90 €
Stand reservation space 6 sqm flat rate (one chair, one table, electricity incl. More details see exhibition contract. Note: a stand registration is only valid with a stand rental contract. After application we will send you the relevant documentation.	<input type="checkbox"/>	1.600 € (1.400 € = early rate until 31.10.2010)

Booking one stand entitles one person (= stand owner) for: full access to all events, Welcome Reception, congress documentation, B2B meetings, bus transfers, two lunch, coffee and soft drinks, certificate of attendance. All other additionally stand personnel have to register the *Exhibitor Rate*. For upgrade with access to all events, stand personnel have to register with the "*Full registration*". In that case the *Exhibitor Rate* is not applicable. *Germany: VAT of 19% has to be added to the rates. VAT free only with international sale. For room reservation in the conference hotel go to: <http://www.hesperia.com/>

PAYMENT CONDITIONS

Registration is only active, if payment is made within 10 days after signing the stand rental agreement. Payments shall be made to account name: HCSI, Account no.: 0107426925, Bank name: Deutsche Apotheker - und Aerztebank, IBAN DE 0330 0606 0101 0742 6925, SWIFT/BIC: DAAEDED

Please bill my credit card: VISA MASTER AMEX Other: _____
Cardholder Name: _____ Valid: _____ / _____ CCV: _____

Date: _____ Signature _____
(Name in capital letters):

With my signature I accept the following cancellation policy: Refunding is 50 % in case of cancellation until 31st of Dec. 2011. Refunding is 25% in case of cancellation until 28th of February 2011. After this date no refunding is possible. I/my company is in the possession of a liability insurance to hold the organizer free from third party liability claims.

Please FAX this document to: +49 89 1011 9221 For questions or assistance, call: +49 89 1011 9222