



Farm to Table: Nourishing a Sustainable Finger Lakes

SATURDAY, June 5, 2010

New York Chiropractic College, Seneca Falls, NY

Exhibit Hours: Saturday, June 5: 10 am – 5 pm

Contact Erin Hart with any questions: Phone: 412/563-7807 Email: ehart@american-healthcare.net

BASIC INFORMATION

Company:				Contact Name:		
Address:				City/State/Zip:		
Phone#:			Fax#:			Email:
# of tables:		# of chairs:		Electricity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Description of Table Presentation						

SPONSORSHIP and EXHIBITOR LEVELS

Small Business - \$300 - Income

<\$50,000/annually

Large Business - \$600 - Income

>\$50,000/annually

Registration includes:

- 1 8 foot table
- Name in program
- If a vendor is late to an event without prior notice, the reserved table may or may not be available upon arrival.

- All exhibitors must provide a certificate of insurance listing New York Chiropractic College as an additional insured.

- By signing below exhibitors agree to comply with all laws and regulations.

Sponsorship Levels – please call

- Customized Exhibit space
- Name & full page ad in program
- Name and logo on website
- Recognition prior to keynote speaker
- Inclusion in press releases
- Event Signage
- Interviews on Air
- Inclusion in all event advertisements

Program Advertising

Back/Inside Cover	\$600
Full Page	\$500
Half Page	\$275
Quarter Page	\$175

Community Health Magazine – 3 month package – March, April, May

Full Page	\$1100/mo.
Half Page	\$650/mo.
Quarter Page	\$500/mo.

Exhibitor Fee _____

Discount – 15% _____

(before 2/28/10) _____

Ad Fee _____

Magazine Ad _____

Extra Tables (\$25 each) _____

Total _____

PAYMENT INFORMATION

Payment is due when you submit this contract. If payment has been received, and a paid exhibitor must cancel; no refund will be issued **Questions? (412)563-8800 Fax: (412)563-8319**

Pay by Check: Checks payable to: **American Health Fairs**, 1910 Cochran Road, Manor Oak One, 600, Pittsburgh, PA 15220

Pay with Credit:
Credit will be processed under the name **American HealthCare Group**. Your credit card bill will reflect this.

Credit Card Type:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express		
Card Number:			Exp Date:
Name on card:			

SIGN HERE: _____ **DATE:** _____