

**COMPANY NAME**

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Please print

**The Agreement**

**PLEASE RETURN ALL FOUR (4) COMPLETED PAGES TO IFD  
See Contact Information on Page 2**

**2009 World Symposium on Denturism**

Hosted by: International Federation of Denturists and National Denturist Association

**Exposition Site**

The Orleans Hotel & Casino  
4500 W. Tropicana Avenue  
Las Vegas, Nevada 89103

**Dates and Hours of Show**

Thursday, October 15 – 8:00 am – 10:00 am (Breakfast)  
Thursday, October 15 – 12 noon – 1:00 pm (Lunch)  
Thursday, October 15 – 4:00 pm – 5:30 pm (Cocktail)  
Morning and Afternoon Breaks will be held in Exhibit Hall (Times TBA)

Friday, October 16 – 8:00 am- 9:30 am (Breakfast)  
Friday, October 16 – 12 noon – 1:00 pm (Lunch)  
Morning and Afternoon Breaks will be held in Exhibit Hall (Times TBA)

**Set up and Tear down times**

Set up: Wednesday, October 14: 12:00 noon – 8:00 pm  
Tear down: Friday, October 16 – 4:00 pm  
(For security reasons, your staff must remain on site until your display is dismantled.)

We, the undersigned, agree to abide by all accompanying terms and general regulations. We hereby make application for exhibit booth(s) at the 2009 World Symposium on Denturism.

**Program listings will be alphabetical and by booth number.**

Product(s)/service(s) to be exhibited (including brand name) – please print clearly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We prefer NOT to be adjacent to the following companies – please print clearly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(The committee will attempt to accommodate this wish if space and set-up allow)

The committee reserves the right to allocate space.

The representatives of the exhibitor are – please print clearly:

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**N.B. : PLEASE NOTE – NO ENTRANCE TO THE EXHIBIT HALL WITHOUT A CONFERENCE NAME TAG. ENSURE ALL BOOTH REPS CHECK IN AT THE SYMPOSIUM REGISTRATION DESK AT THE ORLEANS WHEN THEY ARRIVE, TO PICK UP PERTINENT MATERIALS.**

Exhibitors are welcome to attend individual special events upon payment of the required special event fee. See below.

See the Cancellation Clause in the Exhibit Information document.

Please return this application before **August 3, 2009.**

**Cheque Payment**

Mail your cheque, payable in U.S. Funds to the International Federation of Denturists, to the following address:

International Federation of Denturists  
PO Box 46132 RPO Westdale  
Winnipeg MB R3R 3S3 Canada

Courier to : 67 Bergman Crescent, Winnipeg MB R3R 1Y9 Canada

**FOR MORE INFORMATION:**

Gerry Hansen, Chief Executive  
International Federation of Denturists  
Email: [ifdenturist@mts.net](mailto:ifdenturist@mts.net)

**Authorised by :**

\_\_\_\_\_  
**Name (please print clearly)**

\_\_\_\_\_  
**Company**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**Province/State**

\_\_\_\_\_  
**Country**

\_\_\_\_\_  
**Postal Code / Zip Code**

\_\_\_\_\_  
**Telephone**

\_\_\_\_\_  
**Fax**

\_\_\_\_\_  
**Email address**

\_\_\_\_\_  
**Name of principal contact (if different from above)**  
**[Pertinent conference information will be sent to**  
**this person if different from above].**

\_\_\_\_\_  
**Telephone (if different from above)**

\_\_\_\_\_  
**Fax (if different from above)**

\_\_\_\_\_  
**Email address (if different from above).**

**PAYMENT**

**See Exhibitor Information for exhibit payment and cancellation guidelines. All fees are in U.S. Funds. Non-taxable.**

1 Booth @ \$1200 \$ \_\_\_\_\_

\_\_\_\_\_ Booth(s) x \$900 \$ \_\_\_\_\_

Tote Bag insert @ \$300 \$ \_\_\_\_\_

What Happens in Vegas  
Friday, October 16  
\$100 per person  
\_\_\_\_\_ tickets x \$100 \$ \_\_\_\_\_

Golf Tournament  
Tuesday, October 13  
See [www.international-denturists.org](http://www.international-denturists.org)

Poker Tournament  
Friday, October 16  
See [www.international-denturists.org](http://www.international-denturists.org)

50% Deposit \$ \_\_\_\_\_

Balance Owing \$ \_\_\_\_\_

**PAYMENT IN FULL IS REQUIRED BY August 3, 2009**

Payment Options :

Cheque payable to International Federation of Denturists VISA/MASTERCARD/AMEX

\_\_\_\_\_ Card Number \_\_\_\_\_ Expiry Date

\_\_\_\_\_ Cardholder Name

\_\_\_\_\_ Signature

I authorize IFD to use the above credit card to pay the deposit on receipt of this application, and the balance due by August 3, 2009. (Your credit card statement will show a debit by the National Denturist Association.)

I authorize IFD to use the above credit card to pay the entire amount owing on receipt of this application.

**FORWARD THIS APPLICATION TO:**

**INTERNATIONAL FEDERATION OF DENTURISTS**  
FAX: 1-204-895-9595  
EMAIL: [ifddenturist@mts.net](mailto:ifddenturist@mts.net)

**OR MAIL TO:**  
International Federation of Denturists  
PO Box 46132 RPO Westdale  
Winnipeg MB R3R 3S3 Canada