



The 2012 CIHQ Accreditation and Quality Summit
“Making Your Kingdom Magical”
 June 6 – 7, 2012, Doubletree Hotel Anaheim / Orange County
EXHIBIT REGISTRATION FORM

Name of Company (please list exactly as you wish it to appear on the program) _____ Website Address _____

Address _____ City _____ State _____ Zip _____

Name of Contact Person (Last, First) <- Please print _____ Title _____

Phone _____ Fax _____ E-Mail Address _____

Exhibit Package Requested (check one: see exhibit package description for details)

- CIHQ Partner = FREE Basic Package = \$280 Deluxe Package = \$400

Additional Booth Services

Please contact the Doubletree Hotel Anaheim / Orange County directly for additional services:

Additional Promotional Services Requested (check all that apply)

- Name & logo on conference tote bag..... \$200.00

Advertisement in conference program

- Full page inside front cover \$250.00
 Full page inside back cover \$250.00
 Full page \$150.00
 Half page \$75.00
 Quarter page \$50.00

We understand that all space must be paid for in full by **April 27, 2012**. If assigned space is not paid in full by the specified date, it may be assigned to another exhibitor at the option of CIHQ.
 We agree to abide by the terms and conditions, which are made part of this agreement. This is not a binding agreement until accepted by CIHQ.
 The contact person on this application shall be the official representative of the exhibitor and shall have the authority to certify representatives and act on behalf of the exhibitor in all negotiations. This agreement and related future mailings will be addressed to the contact person on this application.

 Signature of Contact Person _____
 Date

TOTAL AMOUNT DUE: _____ Payment must be received in full by 3/25/11

- If paying by check, make payable to: Center for Improvement in Healthcare Quality
- Credit Card *(a processing fee of approximately 2.5% will be added for all credit card charges)*
 Type: _____ Visa _____ MasterCard _____ American Express

Number: _____ Expires: _____

Name on Card: _____ Card Security Code: _____
 3 digit number on back of card / 4 digit on front for AMEX

Address if Different than Above: _____
 Address _____ City _____ State _____ Zip _____

Signature _____ Date _____

Mail To:
 Center for Improvement in Healthcare Quality
 3101 Briar Oak Lane
 Round Rock, TX 78681

Fax To:
 (805) 934-8588
 Fax is to a secure location

Register by Phone Toll Free (9AM – 5PM PT)
 (866) 324-5080

Please submit – in 50 words or less – a brief description of your company and the services you provide for inclusion into the conference program. Please include this description with your registration and submit in Microsoft Word format.