SPINA BIFIDA ASSOCIATION

2021 CLINICAL CARE MEETING PARTICIPATION AGREEMENT

COMPANY INFORMATION

Company Name____

Contact Person____

Address ____

City, State, Zip ____ Phone ____________________

E-mail ____

EXHIBITOR LEVEL

☐ Exhibitor $500 ☐ Nonprofit Exhibitor $350
☐ Presenting Exhibitor $5,000 ☐ Premier Exhibitor $2,500 ☐ Proud Exhibitor $1,000

PAYMENT INFORMATION

❑ Already paid – carryover from 2020 CCM
❑ Our check/money order payable to the Spina Bifida Association is enclosed/on the way
❑ Please send an invoice to the email address above
❑ Please charge the following credit card
❑ Visa ❑ Mastercard ❑ American Express ❑ Discover

Name on Card: ____

Card Number: ____

Expiration Date: ________________________ Security Code: ________________________________

Signature: ____

Please return this form to:
Elizabeth Merck, Director of Development, at emerck@sbaa.org or Sherita Brace, Foundation & Corporate Relations Manager, at sbrace@sbaa.org or mail to Spina Bifida Association, 1600 Wilson Blvd Ste 800, Arlington, VA 22209. To pay by credit card by phone, contact (202) 618-4754.