



Company Name (as it will appear in marketing materials) \_\_\_\_\_

Mailing Address (as it will appear in marketing materials) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Company Phone \_\_\_\_\_ Company Fax \_\_\_\_\_

Company Website \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

ContactEmailAddress\* \_\_\_\_\_

\*All conference communication will take place via email

Company Category (Please list one) \_\_\_\_\_

50-word Company Description      Please use description from NY23      Included below (or will send today via email)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Booth Selection

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Competitors you'd prefer not to be placed next to:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Kindly note that placement cannot be guaranteed, but every effort will be made to honor your requests.

## BOOTH SELECTION

Mini Booth: \$3,500    Standard Booth: \$4,500    Corner Booth: \$5,500    Premium Booth: \$6,500

\_\_\_\_\_ No. of booths    X    \_\_\_\_\_ Booth Cost    \$ \_\_\_\_\_ Total Due

## PAYMENT INFORMATION

A 50% deposit must accompany this form to reserve sponsorship.  
 Payment is due in full by **Thursday, November 1, 2024**.  
 Payment is due in full for all applications received after **Thursday, November 1, 2024**.  
 NYSPPMA and/or Foundation for Podiatric Medicine will charge the remaining balance  
 to the credit card below on **Thursday, November 1, 2024**.

MasterCard    Visa    American Express    Check Payable to NYSPPMA

Payment Amount \_\_\_\_\_

Card Holder's Name \_\_\_\_\_

Card Number \_\_\_\_\_

Card Address \_\_\_\_\_

Exp. Date \_\_\_\_\_ Security Code \_\_\_\_\_ Card Holder's Zip Code \_\_\_\_\_

Signature \_\_\_\_\_

**Email applications to**  
**kkoza@nysppma.org**

**Fax applications to**  
**646-365-7426**

**Mail applications to**  
**330 West 38th Street**  
**Suite 1105**  
**New York, NY 10018**

