

16TH INTERNATIONAL Myeloma Workshop

NEW DELHI, INDIA • MARCH 1-4, 2017

ANCILLARY EVENT SPACE REQUEST FORM

Complete this form for **EACH** request and submit NO LATER THAN February 10, 2017.

Contact Name: Email Address: Mailing Address: Mailing Address: Phone: Fax: EXHIBITOR/SPONSORED PRIVATE FUNCTIONS & HOSPITALITY SUITES I/we have read the I/MV Guidelines regarding Anciliary Events in the Sponsor Manual and agree to abide by all I/MW General Rules and Regulations and hold harmless the I/MV from and against any and all liability and claims and demands which may arise from or be asserted in connection with the foregoing undertakings and responsibilities. Print Name: Title: Applicant's Signature: Date: Function Name: Pesired Location*: "Meeting space is not available at meeting venue. Function Type: Private F&B Function Investigator/Industry Update Patient Group/Non-Profit Organization Other Number Attending: Attendance: Company Personnel Physician/Company Other am/pm Event Description/Purpose:	Company Name:
Mailing Address: Phone:	Contact Name:
Phone: Fax:	Email Address:
Phone: Fax:	Mailing Address:
EXHIBITOR/SPONSORED PRIVATE FUNCTIONS & HOSPITALITY SUITES I/we have read the IMW Guidelines regarding Ancillary Events in the Sponsor Manual and agree to abide by all IMW General Rules and Regulations and hold harmless the IMW from and against any and all liability and claims and demands which may arise from or be asserted in connection with the foregoing undertakings and responsibilities. Print Name:	
Applicant's Signature:	EXHIBITOR/SPONSORED PRIVATE FUNCTIONS & HOSPITALITY SUITES I/we have read the IMW Guidelines regarding Ancillary Events in the Sponsor Manual and agree to abide by all IMW General Rules and Regulations and hold harmless the IMW from and against any and all liability and claims and demands which may arise from or
Function Name: Desired Location*: *Meeting space is not available at meeting venue. Function Type: Private F&B Function Investigator/Industry Update Internal Sales/Business Meeting Patient Group/Non-Profit Organization Other Number Attending: Attendance: Company Personnel Physician/Company Other Function Date: March , 2017 Start Time: am/pm End Time:am/pm	Print Name: Title:
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□ Patient Group/Non-Profit Organization □ Other Number Attending: Attendance: □ Company Personnel □ Physician/Company □ Other Function Date: March, 2017 Start Time:am/pm End Time:am/pm	*Meeting space is not available at meeting venue.
Function Date: March, 2017 Start Time:am/pm End Time:am/pm	
	Number Attending: Attendance: □ Company Personnel □ Physician/Company □ Other
Event Description/Purpose:	Function Date: March, 2017 Start Time:am/pm End Time:am/pm
	Event Description/Purpose:
This Fee is waived for IMW Sponsors FEE to be charged: \$1,000 Name on Card:	FEE to be charged: \$1,000
Credit Card #: Exp Date:	
Signature: Do <u>not</u> email forms with credit card information. Fee will be processed upon approval of event.	Signature: Do not email forms with credit card information. Fee will be processed upon approval of event.

Return form to:

2017 International Myeloma Workshop c/o SPARGO, Inc. 11208 Waples Mill Road, S-112 Fairfax, VA 22030 Phone: (703) 631-6200; Fax: (703) 679-3938 (secure fax)

Email: imw2017@spargoinc.com

IMW Use Only
Date Received:
Date Approved:
Added to DB: