



WIANA Exhibitor Contract

Company: _____

Representative: _____

Address: _____

Telephone: _____

E-Mail: _____

Fax # : _____

Meeting Requirements

Electricity: YES _____ NO _____

Additional Space: YES _____ NO _____ (1- 8' table per vendor is provided)

Level of Sponsorship

Standard _____ Speaker _____

Corporate _____ Executive _____

Please refer to the attached WIANA guidelines for the levels of sponsorship.

Make checks payable to Wisconsin Association of Nurse Anesthetists and send along with the exhibitor contract to:

Peter Strube
WIANA Treasurer
908 Vista Ridge Dr.
Mt. Horeb, WI. 53572
pstrube3000@yahoo.com