

Please accurately describe what will be on display.

ie: ostomy products, beds, support surfaces, dressings

Company Name: _____

Exhibit Contact Name: _____

Phone: _____

Fax: _____

E-mail contact: _____

Address, City, State: _____

Exhibit Items: Ostomy: _____

Wound: _____

Contenance: _____

Other: _____

All fees must be paid in full by September 30th or a \$100 late fee will apply.

Credit card payment info:

OR

Check Payment:

Mail directly to Donna Golden, 552 Webster St., Rockland, MA 02370-1214, jkdnd@aol.com

Make checks payable to: NER/WOCN

Any questions regarding payment,

Please e-mail or call: Patricia.ebbeling@mwmc.com, 508-383-1238

Tax I.D. #: Please contact Danielle Szarek: dszarek@sjnh.org

Alternate contacts:

Gudrun Eriksson: geriksson@comcast.net

Jen Cluff: jcluff@partners.org