INDUSTRY SPONSORED SYMPOSIUM
ACG 2019 Annual Scientific Meeting & Postgraduate Course
Henry B. Gonzalez Convention Center
October 25-30, 2019
San Antonio, TX

Return To: American College of Gastroenterology
Meetings & Exhibitions
6400 Goldsboro Road, Suite 200
Bethesda, MD 20817
TEL: 301-263-9000
FAX: 301-263-9025
emccubbin@gi.org

Please fill out one application for each time slot request. Indicate your top 3 preferences for date/time by numbering 1-3 beside the time slots listed below (note: times are filled on a first come, first served basis with priority given to companies who sponsored a symposium at the 2018 Meeting):

The available time slots designated for symposia programs this year are as follows:

_____	Friday, October 25	5:30 p.m. – 7:30 p.m.
_____	Friday, October 25	7:30 p.m. - 9:30 p.m.
_____	Saturday, October 26	5:30 a.m. - 7:30 a.m.
SOLD OUT	~~Saturday, October 26~~	~~5:30 p.m. - 7:30 p.m.~~
SOLD OUT	~~Saturday, October 26~~	~~7:30 p.m. - 9:30 p.m.~~
_____	Sunday, October 27	5:30 a.m. - 7:30 a.m.
SOLD OUT	~~Sunday, October 27~~	~~7:30 p.m. - 9:30 p.m.~~
_____	Monday, October 28	5:30 a.m. - 7:30 a.m.
SOLD OUT	~~Monday, October 28~~	~~7:00 p.m. - 9:00 p.m.~~
_____	Tuesday, October 29	5:30 a.m. – 7:30 a.m.
_____	Tuesday, October 29	7:00 p.m. – 9:00 p.m.

Preferred room set: □ Banquet □ Theater □ Schoolroom
Expected number of attendees: _____
What is the topic of the symposium? _____
Will CME be offered to attendees? □ Yes □ No
Will a meal be included? □ Yes □ No

If you require additional meeting space in conjunction with this symposium, please fill out the information below:
Number of attendees: _____ Preferred room set: _____
Date(s):_____ Times:_____
(Please note there is a $1,000.00 fee per room per day for each additional room)

PLEASE FORWARD PAYMENT OF $60,000 TO RESERVE A TIME SLOT FOR YOUR SYMPOSIUM ALONG WITH THIS APPLICATION. If you wish to pay by credit card, please fill in the necessary information below. American Express, VISA, and MasterCard accepted. A service fee of 4% will be applied to each credit card payment.

Company: _____

Address: _____

Contact: _____

Telephone: _____ Fax: _____

E-Mail: _____

Credit Card: _____

EXP. Date: _____ CCV: _____

Signature: _____