New England Ophthalmological Society

2025-2026 Program Year
EXHIBITOR REGISTRATION FORM

Company Information

PLEASE RESERVE EXHIBIT SPACE FOR:

Company name _____
(Exactly as you wish to be listed in the printed program)

Address: _____

Telephone: (_____) _____

Email: _____

Website: _____

Contact person: _____
(*For this meeting*) (name) email (if different than above)

Exhibit Fee Schedule

_____ would like to sponsor at the following meeting(s) at the indicated level:
(please enter your company name on this space)

1. **Friday, Sep 19, 2025** ☐ Silver Exhibitor ($2,200) – 1 table
Venue: Boston Marriott Copley Place ☐ Gold Exhibitor ($3,850) – 2 tables
(AM – Cataract; PM – Pediatrics; OMP meeting all day)

2. **Friday, Dec 5, 2025** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
(AM – Risk Management; PM – Cornea)

3. **Friday, March 6, 2026** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
(AM – Retina; PM1 – Eye Care Delivery; PM2 – Oncology)

4. **Friday, Jun 5, 2026** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
(AM – Uveitis; PM1 – Glaucoma; PM2 – Update on Clinical Trials)

------ *over* ------

New England Ophthalmological Society

Exhibit representatives

Please send the name(s) and email address(es) of your representative(s) for each meeting that you will participate on to mocque@mms.org. The total number of representatives should match your participation level (see prospectus).

Exhibit selection summary

Exhibit Day		Amount ($)
1. Friday, Sep 19, 2025:		$_____
2. Friday, Dec 5, 2025:		$_____
3. Friday, March 6, 2026:		$_____
4. Friday, Jun 5, 2026:		$_____
	Sub-total:	$_____

Discount (20%): ***Only applicable*** *if you* ***sign-up and pay in full for all 4 Exhibit days before Sep 19, 2025.***

Are you attending ALL 4 Exhibit days? YES ☐ NO ☐

20% Discount:	$_____
Total due:	$_____

Payment

Your total Exhibit fees are required on or before your meeting participation or your reservation will be cancelled. Online payment is available via private link upon request.

☐ A check payable to NEOS in the amount of $_____ will be mailed to the address below.

☐ Please send me a private link for online credit card payment

PLEASE RETURN FORM AND CHECK TO:
New England Ophthalmological Society
860 Winter Street, Waltham, MA 02451
Email: neos-eyes@mms.org