New England Ophthalmological Society

2026-2027 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: _____
(name) email (if different from 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, Oct 2, 2026** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
AM – Practice Management (with Hutchinson Lecture)
PM – Cornea (with Hal Freeman Lecture)
Ophthalmic Medical Personnel Meeting (all day)

2. **Friday, Dec 4, 2026** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
AM – Glaucoma (with Chandler Grant Lecture)
PM1 – Videos of Latest techniques
PM2 – Plastics

3. **Friday, March 5, 2027** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
(AM – Cataract (with Pender Lecture)
PM – Debates

4. **Friday, May 21, 2027** ☐ Silver Exhibitor ($2,200) – 1 table ☐ Platinum Exhibitor ($4,250) – Glass Rm
Venue: Hotel Commonwealth ☐ Gold Exhibitor ($3,250) – 2 tables
AM – Retina (with Taylor Smith Lecture)
PM1 – Neuro-ophthalmology (with Simmons Lecture)
PM2 – Rescue Therapies

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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, Oct 2, 2026:	$_____
2. Friday, Dec 4, 2026:	$_____
3. Friday, March 5, 2027:	$_____
4. Friday, May 21, 2027:	$_____
Sub-total:	$_____

Discount (10%): *Only applicable if you sign-up and pay in full for all 4 Exhibit days before Oct 2, 2026.*

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

10% 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

Agreement

Restriction of Promotional Activity: by completing and signing this form the exhibit company agrees that all marketing, sales presentations, and collateral distribution must occur strictly within their assigned exhibit space.

Signature: _____ Date: _____