American Headache Society®
6[1st] Annual Scientific Meeting
July 11 - July,14, 2019
Philadelphia Marriott Downtown Hotel
Philadelphia, PA

ANCILLARY MEETING / EVENT REQUEST FORM

Please complete all sections. If your request is for multiple events, **please submit a complete form for each event**. All requests for ancillary meetings must be submitted no later than **Friday, March 15, 2019**. **All requests will be given a final disposition no later than Monday, April 15, 2019**. Upon approval from AHS, you will be provided with a contact name at the venue to assist in setting up your event. You are responsible for all event costs, including but not limited to:

- Room Rental - $500.00/room, per day, invoice will be sent upon approval of request. Acceptable form of payments: Check payable to AHS, Visa, MasterCard, American Express
- Food & Beverage and Audio Visual
- Attendee costs (airfare and applicable room nights)
- Cancellation requests must be received by June 24. No Refunds will be provided after June 24.

Please note that the contact person on the request form will be the only individual AHS staff and hotel staff will communicate with during the pre-planning process as well as onsite for your event/meeting. Please be sure to keep this in mind when completing the form.

Ancillary meetings may be held only during non-conference hours. Meetings are permitted on the following dates and times:

- Monday, July 8, 2019 – All day
- Tuesday, July 9, 2019 – All day
- Wednesday, July 10, 2019 – After 7:30 pm
- Thursday, July 11, 2019 – After 8:00 pm
- Friday, July 12, 2019 – After 6:30 pm
- Saturday, July 13, 2019 – After 5:00 pm
- Sunday, July 14, 2019 – After 10:00 am

Incomplete forms will NOT be processed. ***Please print legibly***
One (1) person must be appointed as liaison to the American Headache Society®. We are unable to accept instruction, direction, inquiries or likewise from any person(s), company(ies), or agent(s) other than the person named below.

Contact Name: _____

Company: _____

Address: _____

City, State, Zip: _____

Telephone/Email: _____

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Meeting Title: _____

Event 1st choice date: _____ Time: _____

Event 2nd choice date: _____ Time: _____

Event 3rd choice date: _____ Time: _____

Number of attendees: _____

Meeting purpose (50 words or less): _____

_____

_____

_____

List of attendees (or attach separately) **REQUIRED** _____

_____

_____

_____

_____

Please return completed form:
American Headache Society®
19 Mantua Road, Mt. Royal, NJ 08061
Telephone: 856-423-0043 / Fax: 856-423-0082 / email: ahshq@talley.com