Please submit completed form and any necessary information to **marketingteam@ceenta.com or 704.295.3445.**

Health/Wellness/Vendor Fairs Participation Evaluation Form

Name of Event:			
Contact Person:			
Name:	Phone:		
E-mail:		_	
Event Information:			
Date of event:	Tim	e of event:	
Set up time:	# of expected attendees:		
If a company event, what insurance carri	er do you have?		
Facility of event:			
Address of event:			
		State: Zip code:	
Cost of event if any?			
# of vendors: (Other healthcare vend	ors:	
First time event:	☐ Yes	□No	
Is the event located:	□ Indoor	☐ Outdoor	
Is a raffle item needed to participate:	☐ Yes	□No	
Screenings requested: (hearing screening	s must have their own	orivate room for noise reduction)	
	☐ Vision	☐ Hearing	
CEENTA office that would benefit:			
Items provided:			
Table	☐ Provided	☐ Not provided	
Chairs	☐ Provided	☐ Not provided	
Tent if outdoors	☐ Provided	☐ Not provided	
Electricity	☐ Yes	□No	