



**TMD for DSM Dentist Workshop
February 28-March 1, 2026
Exhibit Application**

Company Information

Company Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Please select the category(s) that best describes the products and/or services you offer. Check all that apply.

Bite Gauges and Bite Forks

PDAC-Verified Devices

Education

Practice Management

Oral Appliances

Home Sleep Apnea Tests (includes pulse oximetry)

Contact Information

Contact Person Name: _____ Email: _____

For all application correspondence

On-site Representative Name: _____

Exhibit Fee

Exhibit Fee: \$1,000

Space is available on a first-come, first-served basis and limited to seven companies.

The workshop is restricted to dentists who are registered for the AADSM TMD for the DSM Dentist Workshop. Exhibitors will not be permitted in the rooms in which the workshop is taking place.

Payment Information

_____ Credit Card (Visa/Master Card/American Express/Discover)

We will contact the number provided below for the credit card number.

Total: \$

Name:

Phone:

Expiration Date:

Validation Code:

Cardholder's Name:

Signature:

Date:

_____ Check (U.S. dollars only) - make payable to the AADSM

Agreement/Signature

We agree to abide by the exhibit rules and regulations and any amendments thereto, all of which are indicated in the exhibition information on the AADSM website at https://www.aadsm.org/docs/Exhibitor_Rules_and_Regulations_for_Courses.pdf. We understand each company is limited to one table.

Signature: _____ Print Name: _____

Send this form to the AADSM National Office via mail, email or fax.

Attn: Kristin Roy-Chowdhury

Mail: 901 Warrenville Rd., Suite 180, Lisle, IL 60532

Email: kroychowdhury@aadsm.org Fax: (630) 686-9876