

Skylight Market Kiosk Application Form

Name of Contact: _____

Name of Company / Business: _____

Full Address: _____

Telephone Number: Bus: _____ Home: _____ FAX: _____

E-mail address: _____

Items for Sale: _____

PLEASE INDICATE WHICH KIOSK YOU WOULD LIKE TO BOOK

Round Kiosk
Rental Fee: \$150.00

Korner Kiosk
Rental Fee: \$100.00

The Credit Valley Hospital Kiosk Booking Contract

I understand that my application/items for sale must be approved before a booking date will be granted and that The Credit Valley Hospital reserves the right to decline vendor applications based on appropriateness and/or acceptability of product lines.

I will ensure that payment is submitted to the coordinator no less than one month prior to my booking date. I understand that cancellations without 48 hours notice will result in the forfeiture of the rental fee plus a \$20 fine.

I acknowledge receipt of and agree to comply with **ALL policies and procedures**. I am aware that failure to comply with these arrangements will result in the cancellation of future Kiosk bookings with The Credit Valley Hospital.

Signature of Vendor

Date

Please mail to:

Theresa Darby
Skylight Market Coordinator

Communication and Public Affairs Department, 4th Floor
The Credit Valley Hospital
2200 Eglinton Ave. West
Mississauga, ON
L5M 2N1