



TEXAS CHRISTMAS TREE GROWERS ASSOCIATION 2026 EXHIBITOR/VENDOR REGISTRATION FORM

TCTGA Event Dates: August 28 - 30
Hilton Garden Inn Temple Medical Center
www.texaschristmastrees.com for online registration!
PLEASE PRINT OR TYPE

COMPANY NAME: _____

COMPANY OWNER: _____ **CELL:** (____) _____

ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____

PHONE: (____) _____ **FAX:** (____) _____ **REP CELL:** (____) _____

EMAIL: _____

MAIN EXHIBITOR/VENDOR CONTACT

NAME: _____ **TITLE:** _____

CELL: (____) _____ **E-MAIL:** _____

EXTRA COMPANY EXHIBITOR/VENDOR PERSONEL:

1) _____

2) _____

3) _____

EXHIBITOR REGISTRATION & SPONSORSHIP OPPORTUNITIES

EXHIBITOR CONVENTION REGISTRATION FEE \$200 (one table) (2 people)

(Reg. Includes: **Sat. Lunch & Banquet Dinner** and logo and contact info in **Onsite Program**)

___ **ADDITIONAL EXHIBITOR STAFFING** **X#** _____ @ \$50 each **all meals**

___ **NEED ELECTRICITY AT YOUR BOOTH** ___ **YES** ___ **NO** @ \$ 35.....

EXHIBITOR "SPONSORSHIP" SUPPORT

___ **Sat. Luncheon Sponsors** (Full pg ad in Newsletter , (5 minute presentation) @ \$ 200.....

___ **Sat. 46th Dinner** (Full pg ad in Newsletter + (5 minute presentation) @ \$ 300.....

___ **Coffee Break Sponsorships**...(5 minute presentation)@ \$ 100.....

Will you be donating a Auction Item for TCTGA's Auction: ___ **Yes** or ___ **NO**

Name of Auction Item: _____ (Value of Item)\$ _____

Registration & Sponsor Fees

\$ _____ **AFTER 8/21+\$20.00**

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

Payment Information Methods

(Check One) ___ **Check** or ___ **Money Order** **Total Amount: \$** _____

FAX: Registration form to: 254-613-9099 or **Email** to sawmhq@gmail.com or

MAIL: Check payable to: **TCTGA 2202 S. 51st Street, Temple, TX 76504.** Any Questions Call: 512-850-0365

Payment MUST be received 10 days prior to meeting to avoid the \$50 late fee.

Credit Card ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Card Number: _____ **Expiration Date:** _____

Name on Card (please print): _____ **Signature:** _____

CARD Billing Address: _____ **City:** _____ **Zip:** _____

Refund Policy: All cancellation notices must be made in writing by 8/21/2026 and a \$25 administrative fee will be charged. **No refunds after August 21, 2026.** *Privacy Policy: All Credit Card Information is kept confidential*