ADVERTISING SPACE COMMITMENT

Cap Scan

Made this ____ day of ____, 2017 by and between Capital Medical Society &

Advertiser Name _____

Billing Address_____

Contact Person_____

Phone _____ Fax _____ Email _____

Ad Size_____ Color or B&W (circle one) Rate (per issue) _____

January_____	**April_____**	**July_____**	**October_____**
February_____	**May_____**	**August_____**	**November_____**
March_____	**June_____**	**September_____**	**December_____**

Agency_____

Billing Address_____

City_____

Contact Person_____ Phone ( )_____

Fax ( )_____

Details_____

_____

_____

The undersigned hereby authorizes and directs the Capital Medical Society to publish the advertising specified above and pursuant to terms and conditions set forth.

_____	**_____**	**_____**
Authorized Signature/Guarantor	**Title**	**Advertising Sales Rep.**
_____	**_____**	**_____**
Print Name	**Date**	**Date**

Confirmed and accepted by the Capital Medical Society by: _____