

SPONSORSHIP SPACE COMMITMENT

Electronic News

Made this ____ day of ____, 2018 by and between Capital Medical Society &

Sponsor Name _____

Billing Address _____

Contact Person _____

Phone _____ Fax _____ Email _____

Rate (per month) _____

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 sponsorship specified above and pursuant to terms and conditions set forth.

Authorized Signature/Guarantor

Title

Sponsorship Sales Rep.

Print Name

Date

Date

Confirmed and accepted by the Capital Medical Society by: _____