

SPONSORSHIP SPACE COMMITMENT

Website (*www.capmed.org*)

Made this ____ day of ____, 20__ by and between Capital Medical Society &

Sponsor Name _____

Billing Address _____

Contact Person _____

Phone _____ Fax _____ Email _____

Ad Size _____ Rate (per month) _____

January _____ April _____ July _____ October _____

February _____ May _____ August _____ November _____

March _____ June _____ September _____ December _____

Agency _____

Billing Address _____

City _____

Contact Person _____ Phone () _____

Fax () _____

Details _____

Terms of Payment: Contract advertisers are billed monthly. Payment is due upon receipt of invoice. Commitment Form must accompany ad. The Capital Medical Society reserves the right to cancel contract with no notice for late and non-payment of ad.

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: _____