ADVERTISING SPACE COMMITMENT

Cap Scan

Made this ____ day of ____, 20___ 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_____

_____

***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 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: _____