

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/February _____

July/August _____

March/April _____

September/October _____

May/June _____

November/December _____

Agency _____

Billing Address _____

City _____

Contact Person _____ Phone () _____

Fax () _____

Details _____

Terms of Payment: Contract advertisers are billed bimonthly. 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

Print Name

Date

Confirmed and accepted by the Capital Medical Society by:

Signature

Date