Sponsorship Pledge Form

If you would like to support the ACMS and/or ASMH Annual Meetings in Chicago, please complete and return this form to the office. The ACMS and ASMH reserve the right to refuse any product demonstration proposal it deems inappropriate.

Please print clearly.

Company Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ Fax number: _____

Contact name: _____

Title: _____

Signature: _____ Date: _____

Item(s) to be supported:

☐ Product Theater: $35,000 (max. 2 sponsors)

☐ NON-CME Corporate Forum: $45,000

☐ ACMS Registration Packets: $7,500 (max. 1 sponsor)

☐ ASMH Registration Bags: $2,500 (max. 1 sponsor)

☐ Both ACMS and ASMH bags: $8,500 (max. 1 sponsor)

☐ Mobile Charging Station: $5,000 (max. 2 sponsors)

☐ Hotel Key Cards: $5,000 (max. 1 sponsor)

☐ ACMS Notepads: $3,000 (max. 1 sponsor)

☐ ACMS Lanyards: $2,500 (max. 1 sponsor)

☐ ASMH Lanyards: $800 (max. 1 sponsor)

☐ Both ACMS & ASMH Lanyards: $3,000

☐ ACMS and ASMH Registration Packet and Bag Insert: $1,500

☐ Mobile App: $5,000 (max. 1 sponsor)

☐ Hotel Door Drops: $5,000

Final Program Advertising

☐ Full page: $1,500 ☐ Half page: $1,000 ☐ Quarter page: $500

If you're interested in donating cryostats or workshop supplies, please contact Mary Randall at mrandall@mohstech.org or call (414) 918-9813.

☐ Product Theater

We will participate in the demonstration session to showcase our (product / service):

_____

_____

_____

Sponsorship/Support *(also complete pages 11 and 12)*

Please find discount rates for corresponding sponsor rates below.

☐ Platinum Level ($25,000) 16' x 20' Booth Included

☐ Gold Level ($15,000) 10' x 10' Booth Included

Support amount: $ _____

+ Exhibit booth rental $_____

= Total Amount Due: $_____

Payment

Make check payable to American College of Mohs Surgery (ACMS) (US Funds drawn on a US bank only) or provide credit card information (Visa, MasterCard, or American Express). Checks are to be received no later than February 23, 2018.

☐ Check enclosed (Made payable to ACMS) ☐ Visa ☐ MasterCard ☐ American Express

Credit Card Number: _____ Expiration Date: _____

Cardholder's Name: _____ Cardholder's Signature: _____

This is your invoice and contract. No additional invoice will be issued.

Please fax or mail this form to:

American College of Mohs Surgery (ACMS)
555 East Wells Street, Suite 1100
Milwaukee, WI 53202
USA
Phone: (414) 347-1103
Fax: (414) 276-2146

Thank you!