MAYO CLINIC

March 7, 2012

Dear Exhibitor:

On behalf of Mayo Clinic and Course Director Paul Brazis, MD we would like to invite your company to display at the *Neuro-Ophthalmology Update and Review,* September 14-16, 2012, being held at the Loews Portofino, Orlando, Florida. This course expects approximately 75 attendees and is designed for physicians and mid-level providers who treat neuro-ophthalmologic patients especially neurologists, ophthalmologists, optometrist, and neurosurgeons.

The course will review multiple topics in clinical neuro-ophthalmology. At this time, we are extending an invitation of support to leaders in the industry and hope that you will find this symposium to be of great interest. Exhibit fees of **$1000** are sought, which would include table-top display (six foot tables) and two representatives exhibiting during the three-day meeting, listing in the syllabus, and recognition during the meeting.

I look forward to your participation in our conference. If you need additional information, or if I can answer any questions, please don't hesitate to call me at (904) 953-7105.

Sincerely,

Marlana Beck, MPA
Education Specialist
Mayo Clinic Tax ID: 59-3337028

Check payable to Mayo Clinic
Attn: Sheila Newby
4500 San Pablo Road
Jacksonville, Florida 32224

MAYO CLINIC

Mayo School of Continuous Professional Development (MSCPD)

Exhibitor Agreement

Regarding the Terms and Conditions for a Commercial Exhibit

Activity Title: __Neuro-Ophthalmology Update and Review Activity Number: 2012j369__

Location: _Loews Portofino Bay Hotel at Universal Orlando, Orlando, FL_ Date(s) September 14-16, 2012

Agreement between: ACCREDITED PROVIDER (PROVIDER):
College of Medicine, Mayo Clinic – Mayo School of CPD
AND

Name of Commercial Company (EXHIBITOR): _____
(as it should appear on printed materials)

Name of Person Exhibiting:_____

Address: _____

Telephone: _____ Fax: _____ Email: _____

The named EXHIBITOR wishes to exhibit at the above named activity for the amount of $__1000_____

Payment Information

Please complete credit card information or indicate if mailing a check:

☐ Visa ☐ Master Card ☐ Discover

Card # _____ Exp. _____

Name on Credit Card: _____ Date:_____

Address of Cardholder: _____
(if different from above address)

City: _____ State: ____ Zip _____

Phone #: ___ ___ ____ Email: _____

Federal Tax ID number is 59-3337028

☐ **Check**	☐ **Electronic Transfer**
Make check payable to **Mayo Clinic Florida** and remit to: Mayo School of Continuous Professional Development Attn: Marlana K. Beck 4500 San Pablo Rd Jacksonville, FL 32224 (Identify activity number on check _2012j369)	$25 fee Please contact CME office for account information. 904-953-7114

By signing below, I agree to the "Terms and Conditions" outlined on Page 2 of this Exhibitor Agreement (including ACCME Standards for Commercial Support):

EXHIBITOR Representative: _____
(I understand and agree that typing my name above is the electronic equivalent of a written signature) (Date)

PROVIDER Representative: Kate Ray _____ Kate Ray _____
Operations Manager (Signature) (Date)

TERMS AND CONDITIONS

- EXHIBITOR agrees to abide by ACCME Standards for Commercial Support as stated at www.accme.org:
  SCS 4.2: "Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CME." "Live, face-to-face CME, advertisements and promotional materials cannot be displayed or distributed in the educational space immediately before, during or after a CME activity. **Providers cannot allow representatives of Commercial Interests to engage in sales or promotional activities while in the space or in the place of the CME activity."**
- EXHIBITOR may not distribute promotional materials. Distribution of pharmaceuticals or other samples is prohibited.
- All commercial support associated with this activity will be given with the full knowledge of the PROVIDER. No additional payments, goods, services or events will be provided to the course director(s), planning committee members, faculty, joint sponsor, or any other party involved with the activity.
- Completion of this agreement represents a commitment and payment is due and collectible by the ACTIVITY DATE unless otherwise agreed upon by the PROVIDER. PROVIDER reserves the right to refuse exhibit space to EXHIBITOR in the event of nonpayment or Code of Conduct violation.
- PROVIDER agrees to provide exhibit space and may acknowledge EXHIBITOR in activity announcements. PROVIDER reserves the right to assign exhibit space or relocate exhibits at its discretion.
- PROVIDER **Federal Tax ID number is 59-3337028**.
  Please remit check payable to: **Mayo Clinic Florida.** Please identify name of activity on the check stub.

Please fax completed Exhibitor Agreement to: (904) 956-3095
Return via *fax only*