MAYO CLINIC

200 First Street SW
Plummer 2-60
Rochester, Minnesota 55905

Mayo School of Continuous Professional Development

On behalf of the Mayo School of Continuous Professional Development, I am pleased to announce the **11th Annual Mayo Clinic Hematology Review** course on **January 25, 2014** at the graves | 601 hotel in Minneapolis, MN**.**

The opportunity for health care providers to meet with various representatives to discuss products and services is often limited. As a colleague and key representative in an ever-changing health care industry, we invite you to participate in our program to share information with our attendees. We anticipate 150 attendees at this year's course. ***We will have exhibits as part of the program and the fee to display at this course is $1,500.***

If you are interested in exhibiting at this educational activity, please return the enclosed registration form and letter of agreement to the address on the form. For your information, the Mayo Tax ID Number is 41-6011702, please make checks payable to Mayo Clinic and include the course name on the check.

If you have any questions or need additional information, please contact Kammi Englund directly at 507-266-3323 or (englund.kammi@mayo.edu).

Sincerely,

Sierra Tollefson

Sierra Tollefson
CME Specialist

Mayo School of Continuous Professional Development
11th Annual Mayo Clinic Hematology Review
January 25, 2014
Exhibitor Registration Form

(Please print/type information exactly as you want it to appear on the name tag.)

Company Name: _____

Name of Primary Exhibitor: 1._____

Name of Additional Exhibitor: 2._____

Mailing Address: _____

City/State/Zip Code: _____

Telephone Number: _____

Fax Number: _____

E-mail address: _____

(*a maximum of two representatives are allowed per exhibit).

For your information, the Mayo Tax ID Number is 41-6011702. Please make checks payable to Mayo Clinic and include the course name on the check.

Our company will: *(please check the appropriate box)*

- ☐ Support this course with an exhibit fee $___1500___.
- ☐ Decline to participate at this time. Please keep my name and address on file for future opportunities.

Display Information: A 6' table will be provided for your exhibit.

Complete and return this form along with a company check to:
Kammi Englund
Mayo School of CPD
Plummer 2-60
200 First Street, SW
Rochester, MN 55905
Phone: 507-266-3323 FAX: 507-538-7234
E-mail: englund.kammi@mayo.edu

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Exhibitor Agreement

Regarding the Terms and Conditions for a Commercial Exhibit

Activity Title: 11th Annual Mayo Clinic Hematology Review
Location: Minneapolis, MN Date(s) January 25, 2014

Agreement between: ACCREDITED PROVIDER (PROVIDER):
Mayo Clinic College of Medicine – Mayo School of CPD
AND
EXHIBITOR: _____
Telephone _____ Fax_____ Email_____

The named EXHIBITOR wishes to exhibit at the above named activity for the amount of **$1,500**.

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 distribute promotional materials at their exhibit space only. Distribution of drugs 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 booth space and to 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 41-6011702**.
  Please remit check payable to: Mayo Clinic. Please identify name of course on the check stub.

AGREED

EXHIBITOR Representative: _____ _____
(Name) (Signature)

PROVIDER Representative: _____ _____
Mayo School of CPD (Signature)
200 First Street SW
Rochester, MN 55901
Telephone: 507-266-7992 Fax: 507-538-7234