Indiana Podiatric Medical Association
2010 Fall Convention
October 14-16, 2010
Hyatt Regency Indianapolis, One S. Capitol Avenue,
Indianapolis IN 46204
EXHIBITORS REGISTRATION FORM

COMPANY NAME: ____

ADDRESS: ____

CITY: ______________________________STATE: __________ZIP: _______________________

TELEPHONE NUMBER: ______________________FAX___________________________________

E-MAIL: __________________________________ CONTACT PERSON: _____________________

REPRESENTATIVES NAMES ADDRESSES AND TELEPHONE NUMBERS (If different from above):

____

____

____

ELECTRICAL OUTLET needed for out display:
120-Volt Circuit Number Needed _____________________

COMPANY'S NAME as it should appear in the printed program. (If different than the one listed above):

____

Booth Information Number of exhibit spaces requested _________

Desired Location: 1st choice _____ 2nd choice _____ 3rd choice _____
PREMIUM BOOTHS: 6, 15, 16, 25, 26 and 36
List any companies which you would prefer not to be placed next to. Requests will be honored if feasible.

____

AMOUNT ENCLOSED

EXHIBIT: $500.00 per booth registration fee ___________________

$800.00 per premium booth registration fee ___________________

CHECKS SHOULD BE MADE PAYABLE TO AND RETURNED ALONG WITH THIS FORM
BEFORE SEPTEMBER 1, 2010 TO:

INDIANA PODIATRIC MEDICAL ASSOCIATION
101 W. Ohio Street Suite 780
Indianapolis IN 46204
317-222-3847
Fax: 317-222-3849

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9/28/09
#702.5

Indiana Podiatric Medical Association
2010 Fall Convention
ADDITIONAL SPONSORSHIP OPPORTUNITIES/SOCIAL FUNCTIONS

COMPANY NAME: ____

ADDRESS: ____

CITY: _______________________________STATE: __________ZIP: ________________________

TELEPHONE NUMBER: ______________________FAX____________________________________

E-MAIL: ____________________________________ CONTACT PERSON: ______________________

ADVERTISEMENTS
Program ½ page ad = $100.00 $__________

Program Full page ad = $250.00 $__________

INNOVATIVE HOUR
10-minute Product Presentation at Friday's Lunch = $500.00 $__________

SOCIAL FUNCTIONS
Continental Breakfast = $3500.00
❑ Friday ❑ Saturday $__________

Breaks = $1200.00
❑ Thursday ❑ Friday AM ❑ Friday PM
❑ Saturday AM ❑ Saturday PM ❑Sunday $__________

CONTINUING MEDICAL EDUCATION SPONSORSHIP OPPORTUNITIES

We ("the Company") will provide support for the following continuing medical education activity as indicated below:

Total of CME Activity ____

Location ____Date(s) ______________________

❑ Unrestricted educational grant for support in the amount of $____________________________

❑ Restricted grant to reimburse expenses for:

❑ Speaker(s) ____
___ Lodging
___ Travel Expenses
___ Honorarium in the amount of (determined by course director) $__________

❑ Support of catering functions in the amount of $______________________________
(specify function) ____

❑ Other (e.g., audio-visual equipment, brochure distribution, etc.) __________________

PLEASE CONTINUE ON REVERSE

CONDITIONS

1. **Statement of Purpose**: program is for scientific and educational purposes only and will not promote the Company's products, directly or indirectly.

2. **Control of Content and Selection of Presenters and Moderators**: IPMA is ultimately responsible for control of content and selection of presenters and moderators. Company, or its agents, will respond only to sponsor-initiated requests for suggestions of presenters or sources or possible presenters. IPMA will determine role of Company, or its agents, in suggesting presenter (s) based on balance and independence.

3. **Disclosures of Financial Relationships**: IPMA will ensure disclosure to the audience of (a) company funding and (b) any significant relationship between the IPMA and the Company (e.g., grant recipient) or between individual speakers or moderators and the Company.

4. **Involvement in Content**: there will be no "scripting", emphasis, or influence on content by the Company or its agents.

5. **Ancillary Promotional Activities**: no promotional activities will be permitted in the same room or obligate path as the educational activity. No product advertisements will be permitted in the program room.

6. **Objectivity & Balance**: If the Company's products or services (or competing products or services) are discussed, IPMA will make every effort to ensure that speakers in an objective manner, describe any limitations of the data, and give a balanced report of the products or services and their alternatives.

7. **Discussion of Unapproved Uses**: IPMA will require that presenters disclose when a product is not approved in the United States for the use under discussion.

8. **Opportunities for Debate**: IPMA will ensure opportunities for questioning or scientific debate.

9. **Independence of IPMA in the Use of Contributed Funds**:

   a. Funds should be in the form of an educational grant made payable to the sponsor.

   b. Any other support by the Company for the CME program (e.g., distributing brochures, preparing slides) must be given with the full knowledge and approval of the sponsor.

   c. No other funds will be paid by the Company to the program director, faculty, or others involved with the CME activity (additional honoraria, extra social events, etc.).

10. **Company Representative**: representative of the Company may attend the program, but may not engage in any promotional activities while in the room which the program takes place.

11. **Company Sponsored Social Events**: the Company will not sponsor any social event which competes with, or takes precedence over, the program.

12. **Cancellation**: this Agreement may be cancelled by mutual agreement at any time or by IPMA upon written notice to the Company.

13. **Indemnification**: the Company shall indemnify and hold IPMA harmless from and against any and all loss, expense, or damage to IPMA arising out of the negligence, willful misconduct, or breach of this Agreement by the Company, its agents, or employees.

The Company agrees to abide by all requirements published in *CPME 720, Standards, Requirements and Guidelines for Approval of Sponsors of Continuing Education in Podiatric Medicine* (appended).

The IPMAC shall: 1) abide by the requirements published in *CPME 720, Standards, Requirements and Guidelines for Approval of Sponsors of Continuing Education in Podiatric Medicine*; 2) acknowledge educational support from the Company in program brochures, syllabi, and other program materials: and 3) upon request, furnish the Company a report concerning the expenditure of the funds provided.

AGREED

Company Representative (print name) ____

Signature ________________________________ **Date** ____________________

IPMA Representative (print name) ____

Signature ________________________________ **Date** ____________________

Make a copy of this application for your records. Mail commitment form and full payment to:

Indiana Podiatric Medical Association 101 W. OHIO STREET SUITE 780

INDIANAPOLIS IN 46204

If paying by credit card, fax entire form to 317-222-3849. Questions? 317-222-3847

PAYMENT METHOD:

Payment type (check one).

Check enclosed: ___ Mastercard: ___Visa: ___ Discover: ___

____

Credit Card Number (please print clearly) plus Three Digit Card Identification Data (on back of card)

____

Expiration Date

____

Name on Card (please print) Authorized Signature