



10985 N. Harrell's Ferry Rd., 2nd Floor • Baton Rouge, LA 70816
Phone 225-273-7904 • Fax 225-273-7905 • www.CapitalAMS.org

2011 PARTNER AGREEMENT

(Federal Tax ID #72-6023269)

The Capital Area Medical Society, by receipt of the completed Partner Agreement, accepts this commitment of Partnership from Company/Organization) _____, in the amount of \$_____, which is at the _____ Partner level. This level of support entitles the Company/Organization to all benefits for that level as outlined on the 2011 Partnership Opportunities. If that level of support contains an option for participation at a CapitalAMS Meeting, please indicate, by checkmark, which meeting _____Spring or _____Fall your Company/Organization will attend. Should the integrity of this event be comprised for any reason, the producers of this event can reschedule without penalty. No refunds of support will be issued.

PARTNER

Company/Organization: _____

Representative Name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

By signing this agreement I represent and warrant that I have authorization to execute this binding agreement on behalf of the company/organization named above.

Signature: (Required) _____ Date: _____

Contact Person (If different from Authorized Signer): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Capital Area Medical Society

Name: _____ Title: _____

Signature: _____ Date: _____

**Return your completed Partner Agreement, with payment, to the address indicated above.
For Additional Information Contact: Deanna Menesses 225-273-7904 or Deanna@CapitalAMS.org**

PARTNER OPPORTUNITIES ON REVERSE