Mayo Clinic School of Continuous Professional Development (MCSCPD)
Exhibitor Agreement

Activity Title	17th Annual Mayo Clinic Update in Nephrology and Transplantation 2019
Activity Number	19R06371
Location	Hilton Scottsdale Resort and Villas, Scottsdale, Arizona
Dates	February 15-16, 2019

Agreement between: ACCREDITED PROVIDER: Mayo Clinic College of Medicine and Science – MCSCPD AND:

Company Name (Exhibitor) (as it should appear on printed materials)	
Exhibit Contact (if different then exhibit Rep.)	
Name(s) of Representative(s) exhibiting: (Maximum of two representatives allowed per exhibit)	
Address	
Telephone	
Fax	
Email	
The named exhibitor wishes to exhibit at the above named activity for the amount of	$ 2000.00

NOTE: There may be additional charges depending on the meeting location (power, internet access, etc.).
Please list additional requests here: (please note: additional requests may incur additional fees)

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." "For 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 place of the CME activity."**
- EXHIBITOR may only distribute educational promotional materials at their exhibit space. Distribution of non-educational items (pens, notepads, etc.), pharmaceuticals or product samples is prohibited.
- All exhibit fees 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 provider, 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.

By signing below, I agree to the "Terms and Conditions" outlined on Page 1 of this Exhibitor Agreement (including ACCME Standards for Commercial Support):

The person signing below is authorized to enter into this agreement:

Exhibitor Representative Name	Signature	Date
Mayo Clinic Representative Name	Signature	Date

PAYMENT INFORMATION

Please indicate your method of payment:

PROVIDER **Federal Tax ID number is 41-6011702**.
Please remit check payable to: Mayo Clinic. Please identify name of course on the check stub.

☐ Check	
Make payable to: Mayo Clinic Mayo Clinic Division of Nephrology and Hypertension Mayo Building 19-12 200 First St SW Rochester, MN 55905 Please identify **17th Annual Mayo Clinic Update in Nephrology and Transplantation** on the check.	

Complete and return this form along with your payment made to Mayo Clinic,
Federal Tax ID# 41-6011702
Kathy Hegna Zelinske
Mayo Clinic
Division of Nephrology and Hypertension
Mayo Building 19-12
200 First St SW
Rochester, MN 55905
T: 507-266-1044

17th Annual Mayo Clinic Update in Nephrology and Transplantation
February 15-16, 2019
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 $ 2,000.00 .

☐ Decline to participate at this time. Please keep my name and address on file for future opportunities.

☐ Please remove my name from your files.

Display Information: An 8′ table will be provided for your exhibit.

Complete and return this form along with a company check to:
Kathy Hegna Zelinske
Mayo Clinic
Division of Nephrology and Hypertension
Mayo Building 19-12
200 First Street SW
Rochester, MN 55905
Fax: 507-266-7891
Phone: 507-266-1044
Email: zelinske.kathleen@mayo.edu