



Michigan Pharmacists
A S S O C I A T I O N

Classified Advertising Contract

Date: ___ / ___ / ___

Name of Advertiser: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Agency (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Send Invoice to: _____

Frequency to be charged: ___ X

Classified Type:

- Combination Package Line Advertising Business Card Website

Insertion Dates:

For *Michigan Pharmacist* January March May July September November

For *MPA's Doses* February April June August October December

(please circle)

For MPA Website @ www.michiganpharmacists.org Starting: _____ # of weeks: _____

Special Instructions: _____

Authorizing Agent Signature: _____

Name, Title and Company: _____

Any change in this contract must be submitted in writing 30 days in advance of reserved publication date.

Please send signed contract to Michigan Pharmacists Association, 815 North Washington Avenue, Lansing, MI 48906-5198, fax to (517) 484-4893, or e-mail to communications@michiganpharmacists.org. Call (517) 484-1466 with questions.