



michigan pharmacist

Display 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

Insertion Dates: January March May July September November
(please circle)

MONTH	Ad Name	Size	Color: 4C, 2C or BW	Gross Amount	Agency Discount	Total to be Billed
January						
March						
May						
July						
September						
November						

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 Pharmacist*, 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.