

ALLIANCE OF INDEPENDENT

**ACADEMIC MEDICAL CENTERS**

***2020 PARTNERS PROGRAM***

***Registration Form***

I. LEVEL OF SPONSORSHIP (please check one)

 □ Gold: $10,000 □ Silver: $5,000 □ Bronze: $3,000 □ Exhibitor: $2,500

II. COMPANY CONTACT INFORMATION (for inclusion in the *2020 Partners Directory* brochure)

Company Name:

Contact Person: Title:

Address:

City: State: Zip Code:

Website Address:

Phone: E-Mail:

*If the AIAMC Office’s primary point of contact (for logistics, planning, etc.) is different from what appears above, please list that person’s contact information here:*

Primary Contact: Title:

Phone: E-Mail:

III.COMPANY DESCRIPTION (for inclusion in the *2020 Partners Directory* brochure)

 *Your company description should be 150 words or less.* You may submit this one of two ways:

□ Our company description will be sent via e-mail to kimberly@aiamc.org no later than **November 30, 2019**.

**-OR-**

□ Please use the same description we submitted last year (if applicable).

IV. COMPANY LOGO (for *2020 Partners Directory* and use on-site at the Annual Meeting)

*Your logo should be in an editable JPEG file with minimum 300 dpi resolution.* You may submit this one of two ways:

 □ Our logo will be sent via e-mail to kimberly@aiamc.org no later than **November 30, 2019**.

**-OR-**

□ Please use the same logo as submitted last year (if applicable).

2020 AIAMC Partners Program

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Page 2 of 2

**V. EXHIBIT AT ANNUAL MEETING**

□ Our company WILL have a table-top exhibit at the Annual Meeting, to be held March 26th thru 28th at the Omni Barton Creek Resort and Spa; please send us more information regarding logistics, electrical needs, etc.

**-OR-**

□ Our company will opt out of this partner benefit and does NOT plan to have a table-top exhibit.

**VI. ANNUAL MEETING REGISTRATION**

Online registration opens in mid-November. *All partners must register online, even if the registration fees are waived. Please log onto* [*www.aiamc.org*](http://www.aiamc.org) *to register.* For our planning purposes, please indicate the number of anticipated attendees from your company: □ 1 □ 2 □ 3

VII. PAYMENT

Our partnership support in the amount of $ will be provided to the Alliance of Independent Academic Medical Centers (Fed ID # 01-0492125) as follows (choose one):

□ One check by January 15, 2020 □ Two checks in equal installments by

 January 15, 2020 and March 15, 2020

Please provide your company’s credit card information below; charges will be assessed ONLY if checks are not received as indicated above. *If you prefer for payments(s) to be made by credit card, please check here*: □

A receipt will be emailed to you following credit card transaction(s).

Type of card:□ Visa □ MasterCard □ American Express

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCID Code: Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code of Billing Address: \_\_\_\_\_\_\_\_\_\_

*We agree to abide by all clearly defined expectations and deadlines as stated in writing by the AIAMC as well as all rules and regulations governing the exhibition at the Annual Meeting. I understand that submission of this registration form constitutes a contract.*

Signed: Date:

*Please return your completed Registration Form to*

 *Kimberly Pierce-Boggs, Executive Director, AIAMC*

*NO LATER THAN NOVEMBER 30, 2019*

*Via Email kimberly@aiamc.org*

*Or Fax 888-AIAMC-11 (888-242-6211)*