Stark County Dental Society

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SCDS BULLETIN ADVERTISING CONTRACT

Company Name______________________________ Contact name and title________________________

Mailing/Billing Address____ Phone ( ) _____________

City______________________________ State______ Zip__________ Fax ( )________________

E-mail Address____

Bulletin Advertising Rates per Publication (CHOOSE BELOW)

Black/White *(B/W)* **advertisement**	**1-time only** *(B/W)*	**3-time rate** *(B/W)*	**6-time rate full year** *(B/W)*	**Full Color add-on**
Full-Page	$240	$173	$130	+ $105
Half-Page	$168	$120	$ 94	+ $ 55
Quarter-Page	$120	$ 86	$ 65	+ $ 30
Business Card	$ 78	$ 58	$ 42	+ $ 20

My rate per publication = $________________

____I will take advantage of the 15% discount and pay in full for the 6-time rate for a full year = $_________

____Please invoice me quarterly _____ Use credit card below ______ I will mail a check

Publication schedule: Jan/Feb * March/April * May/June * July/Aug * Sept/Oct * Nov/Dec

Advertising start date:________________ End date:_________________________

______ Please continue running my ad indefinitely and bill me quarterly past the end date.
I will contact with a stop date.

Note: first time Bulletin advertisers – please submit payment along with this signed agreement. Following payment of this first advertisement, you will be invoiced quarterly.

____ Enclosed is a check payable to Stark County Dental Society

____ Check payable to Stark County Dental Society is being mailed today

_____ Please charge to credit card [ ] Master Card [ ] VISA [ ] Discover [ ] American Express

#_______________________________________ Exp. Date_________

____ ________________________
Signature (type your name here) Date