

PROSPECTUS



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Presented in partnership between the Arizona Pharmacy Association and the Arizona ASHP state affiliate.

This 1.5 day seminar provides approximately eleven (11) hours of continuing education, and networking opportunities for pharmacy professionals focusing on clinical topics pertinent to institutional and ambulatory care practice settings. Vendors will have the opportunity to mingle and socialize with the attendees during lunch and breaks.

Attendance expectation: 200



NON-ACCREDITED SPEAKER PROGRAM BREAKFAST

\$30/PERSON* OR \$3,000 FLAT FEE (SATURDAY OR SUNDAY)

- 20-minute non-accredited presentation
- Recognition in on-site program
- Meal function attendee list (name, organization, mailing address)
- Two (2) event passes
- Exhibit booth
- Logo on event web page

NON-ACCREDITED SPEAKER PROGRAM LUNCHEON

\$40/PERSON* OR \$5,500 FLAT FEE (FRIDAY OR SATURDAY)

- 30-minute non-accredited presentation
- Recognition in on-site program
- Meal function attendee list (name, organization, mailing address)
- Two (2) event passes
- Exhibit booth
- Logo on event web page

COMPLIMENTARY SIGNAGE

INCLUDED WITH SPEAKER PROGRAM PACKAGE

- One (1) podium banner
- One (1) door sign

GENERAL SPONSORSHIP

\$1.000

- Recognition in on-site program
 - Logo on event web page
 - Logo on event signage

EXHIBIT BOOTH

\$750

INCLUDES: six-foot table, two chairs and a wastebasket. All attendees will be able to visit booths during breaks and meal functions.

- Name recognition in on-site program
 - Two (2) event passes

ENT CONTRACT FORM

Company Name:		
Corporate Contact Name:		
Address:		
Daytime Phone:		Email:
Local Contact Name (<i>if different from above</i>):		
Address:		
Daytime Phone:		Email:
Package Level/Name:		
Additional On-Site Program Advertisements or Specialty Items:		
Special Considerations:		
Event Pass Information (number of Event Passes are dependent upon support level and event)		
Attendee Names		
1.		
2.		
3.		
4.		
This form must be signed and returned to the AzPA office before acknowledgement and sponsor benefits are given. Balance must be paid in full within 30 days of the event. The Undersigned Agrees to the Amount Indicated Name and Title (please print): Signature: Date:		
Signature:		Date:
Payment Method	□ Check □ VISA □ MasterCard □ American Express □ Discover	
Cardholder Name:		
Card Number:		
Expiration Date:		CVV:
Signature:		_

Make checks payable to Arizona Pharmacy Association

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