

## Mayo Clinic School of Continuous Professional Development (MCSCP) Exhibitor Agreement

Activity Title	Mayo Clinic Hawaii Echo with Multimodality Imaging
Activity Number	2020R915
Location	Kapalua, HI
Dates	January 18 – 23, 2020

Agreement between: ACCREDITED PROVIDER: Mayo Clinic College of Medicine and Science – MCSCP AND:

Company Name (Exhibitor) (as it should appear on printed materials)	
Exhibit Contact (if different then exhibit Rep.)	
Name(s) of Representative(s) exhibiting: (Maximum of two representatives allowed per exhibit)	
Address	
Telephone	
Fax	
Email	
The named exhibitor wishes to exhibit at the above named activity for the amount of	\$

**NOTE:** There may be additional charges depending on the meeting location (power, internet access, etc.).  
Please list additional requests here: (please note: additional requests may incur additional fees)

### TERMS AND CONDITIONS


- EXHIBITOR agrees to abide by ACCME Standards for Commercial Support as stated at [www.accme.org](http://www.accme.org): SCS 4.2: “Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CME.” “For live, face-to-face CME, advertisements and promotional materials cannot be displayed or distributed in the educational space immediately before, during or after a CME activity. **Providers cannot allow representatives of Commercial Interests to engage in sales or promotional activities while in the space or place of the CME activity.**”
- EXHIBITOR may only distribute educational promotional materials at their exhibit space. Distribution of non-educational items (pens, notepads, etc.), pharmaceuticals or product samples is prohibited.
- All exhibit fees associated with this activity will be given with the full knowledge of the PROVIDER. No additional payments, goods, services or events will be provided to the course director(s), planning committee members, faculty, joint provider, or any other party involved with the activity.
- Completion of this agreement represents a commitment and EXHIBITOR is obligated to provide full payment of all amounts due under this agreement by the ACTIVITY DATE unless otherwise agreed upon by the PROVIDER. PROVIDER reserves the right to refuse exhibit space to EXHIBITOR in the event of nonpayment or Code of Conduct violation.

- If this agreement is cancelled by either party forty-five (45) days or more in advance of the Activity Date, PROVIDER will refund the Exhibit Fee less a \$300 processing fee. If this agreement is cancelled by EXHIBITOR less than forty-five (45) days in advance of the Activity Date, the total amount due under this Agreement shall be immediately due and payable to PROVIDER.
- PROVIDER agrees to provide exhibit space and may acknowledge EXHIBITOR in activity announcements. PROVIDER reserves the right to assign exhibit space or relocate exhibits at its discretion.

**Note: All exhibitors must be approved by MCSCPD and this agreement is not binding until both parties have signed. MCSCPD maintains the right to refuse any exhibitor.**

**By signing below, I agree to the “Terms and Conditions” outlined on Page 1 of this Exhibitor Agreement (including ACCME Standards for Commercial Support):**

The person signing below is authorized to enter into this agreement:

Exhibitor Representative Name	Signature	Date
Mayo Clinic Representative Name	Signature	Date
Jessica Hemenway		

**PAYMENT INFORMATION**

Please indicate your method of payment:

PROVIDER **Federal Tax ID number is 41-6011702**

Please remit check payable to: Mayo Clinic. Please identify name of course on the check stub.

<input type="checkbox"/> <b>Check</b>	<input type="checkbox"/> <b>Credit Card or Wire Transfer</b>
Make payable to: Mayo Clinic ATTN: Jessica Hemenway 200 First Street SW – Gonda 6-430 Rochester, MN 55905  Please identify <b>Hawaii Heart 2020</b> on the check.	For payment by credit card or wire transfer, please call the Mayo Clinic CV CME registrars at <b>800.283.6296</b> .  <i>Do not send credit card information via email or fax.</i>

Please complete and return this form along with your payment before **January 1, 2020** to:

Mayo Clinic  
 ATTN: Jessica Hemenway  
 200 First Street SW; Gonda 6-430  
 Rochester, MN 55905

**P:** 507.266.2655 | **F:** 507.266.7403 | **E:** [hemenway.jessica@mayo.edu](mailto:hemenway.jessica@mayo.edu)