

# LETTER OF AGREEMENT FOR COMMERCIAL SUPPORT

## Regarding Terms, Conditions and Purposes of an Educational Grant

(Form must be typed or printed legibly)

Between: **AtlantiCare Regional Medical Center** & \_\_\_\_\_

Title of CME Activity: **12<sup>th</sup> Annual Trauma Symposium**

Location: **Atlantic City Convention Center, Atlantic City, NJ**

Date: **May 10-12, 2009**

### Commercial Supporter

Company name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

The above company wishes to provide support for the named continuing medical education activity by means of (indicate which option):

1. Unrestricted educational grant for support of the CME activity in the amount of: \$ \_\_\_\_.
2. Restricted grant to reimburse expenses for:
  - A. Speaker(s) 1) \_\_\_\_\_ 2) \_\_\_\_\_  
To include:  All Expenses  Travel Only  Honorarium Only  
Honorarium Amount (to be determined by Course Director) \$ \_\_\_\_
  - B. Support for catering functions in the amount of \$ \_\_\_\_  
(specify) \_\_\_\_\_
  - C. Other: (e.g., Exhibit, equipment loan, brochure distribution, etc.) in the amount of \$ \_\_\_\_  
(specify) \_\_\_\_\_

The Commercial Supporter agrees to abide by the Medical Society of New Jersey and the Accreditation Council for Continuing Medical Education's "Standards for Commercial Support of Continuing Medical Education." A report concerning any additional expenditures of funds in support of the activity must be mailed to the Department of Medical Education within 20 days of the activity.

### Commercial Company Agent:

Name (PRINT): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Acceptance of Educational Support by the AtlantiCare Regional Medical Center

In accepting this educational support, the Accredited Sponsor agrees to: 1) abide by the ACCME "Standards for Commercial Support of Continuing Medical Education", 2) acknowledge educational support by the commercial sources in program brochures, and 3) upon request furnish to the commercial supporter a report concerning the expenditure of funds provided.

COURSE DIRECTOR: **Alex Axelrad MD**

TEL: **(609) 441-8023**

AGREED \_\_\_\_\_  
*Alex Axelrad*  
Course Director Signature

DATE \_\_\_\_\_

AGREED \_\_\_\_\_  
Administrator of Medical Education

DATE \_\_\_\_\_

**The Department of Medical Education is pleased to accept this commercial support of the educational activity. Please complete this form and return it 20 days prior to the scheduled event to:**

**Mary Rodgers / Trauma Education Coordinator  
ATLANTICARE REGIONAL MEDICAL CENTER**

**1925 PACIFIC AVENUE, ATLANTIC CITY, NEW JERSEY 08401**  
**FAX: 609-441-8178**