## AAPM\&R Institution Partners Council

Program for all Rehabilitation Institutions and Departments

Support the specialty as AAPM\&R leads the advancement of physiatry's impact throughout health care. Join this program and receive maximum, year-round exposure among your peers and other institutions. Participants also receive significant exposure at AAPM\&R's Annual Assembly. To take advantage of one of these great values, complete the attached registration form

| Value of Participation |  |
| :--- | :--- | :--- |
| Vecognition via AAPM\&R social media channels |  |
| Recognition on AAPM\&R website year-round with clickable description |  |
| Recognition on signage at the Annual Assembly |  |
| Recognition Opportunity: Company logo and 100-word description in an edition of |  |
| The Physiatrist to promote your institution. (Descriptions due by February 6, 2023) |  |

*Values must be used within the calendar year of participation. No credits are provided for unused values. Values are subject to change.
**Separate application required. First-come, first-served, recognition/space may be limited. Deadlines apply. Discounts may not be combined with other offers. ***This is applicable to organizations that exhibit in the Technical Exhibition.
+Space is first-come, first-served.


## AAPM\&R Institution Partners Council Form

Yes, register our institution for the AAPM\&R Institution Partners Council so we can help impact AAPM\&R's vision and immediately start receiving year-round exposure and benefits.

We would like to participate:
O \$5,500
Today's Date $\qquad$

Institution Name: $\qquad$
(Please list name as it should appear in print and online)

Institution Address: $\qquad$
$\qquad$

## PRIMARY CONTACT

Name/Designation: $\qquad$
Email: $\qquad$ Phone: $\qquad$

## SECONDARY CONTACT

Name/Designation: $\qquad$ Title: $\qquad$

Email: $\qquad$ Phone: $\qquad$

## METHOD OF PAYMENT

Payment must be made in U.S. dollars and accompany this form. INVOICE ME O

Enclosed is check \# $\qquad$ Checks must be in U.S. funds and made payable to AAPM\&R.
Charge to the following:
O VISA O MasterCard O DISCOVER O AMEX
Card No.


By signing below, I accept the charges I have indicated on this form. I understand that fees are billed annually.

NAME (please print name as it appears on card)

## PAYMENT INFORMATION

To submit your sponsorship registration form and payment:

SECURE FAX: Fax all pages of this form to: (847) 563-4191

MAIL: Mail this form and payment to:
AAPM\&R
P.O. Box 95528

Chicago, IL 60694-5528
Fees are due for the full calendar year regardless of join date.
Payment in full must be received by AAPM\&R within 30 days of accepting this form.
aapm $\& \mathbf{r}$
American Academy of Physical Medicine and Rehabilitation

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