

## Commercial Exhibitor/Sponsor Agreement CPD Medicine Program, Continuing Professional Development, University of Manitoba

Please check one:		Exhibitor – 6' x 2.5' t Sponsor	able and confe	erence meals for 2	people provided at the activity	
Title of Activity		<u>оролюог</u>		Date of Activity		
Company Name				Representative		
Email:			Telephone:		1	
The National Standard a development, delivery a	applies ind/or e edicine	to all situations where evaluation of accredite policy on <b>Interaction</b>	e financial and indicated CPD activities	n-kind support contri s. Activities must als	or Support of Accredited CPD Activities. Ebutions are accepted for the ocomply with the University of Manitob of Medicine and Health-Related	
					ons with exhibitor(s)/sponsor(s) meet right and contractual law regulations.	
The exhibitor/sponsor a	grees t	o provide the followin	g support for the	e above noted activit	ry:	
☐ Financial support in the amount of: \$				In-kind support (describe):		
	I. Pay	ment must be receiv	ed one week	prior to activity	efore activity date for acknowledgment date and made payable to the CPD ed.	
moderator in the openin	g rema	rks. Exhibitor/sponsor	will be recogniz	ed separately from th	omotional material and verbally by the ne educational content with a statement: ng/sponsoring company.)"	
Arrangements for comm can they be a condition					ng or interfere with the presentation; nor	
					ducational space (lecture theatre, etc.) ute medication or device samples at the	
approval is received fro	m the 0 s, gift c	CPD provider/physicia ertificates, tickets, dev	n organization.	This includes, but is	e gift) at the CPD activity unless written not limited to items such as textbooks, otel accommodations, entertainment or	
Step 1:	То	be Completed by the	Exhibitor/Spo	nsor Representativ	/e	
☐ I Agree	By clic	king "I Agree" you ack	nowledge you v	vill comply with the a	above terms and conditions.	
Date:						
Step 2:	CPD	Medicine Program, Ur 260 Brod		toba, Max Rady Col McDermot Avenue R3E 3P5	lege of Medicine	
Step 3:	То	be completed by CP	D Provider/Phy	/sician Organizatio	n	
Name of CPD Provider/Physician Organization:						
Name of chair/representative:						

Signature of chair/representative: