



ASRA Annual Corporate Partnership Application

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Company Name: _____

Corporate Headquarters Address: _____

Annual Partnership Fee: \$8,000 **For following period:** _____

ASRA Corporate Partner Representative: Each company that is an ASRA Corporate Partner will designate one person who will represent their company to ASRA. This person will also receive all mail and email correspondence regarding Corporate Partnership. A company may choose to designate a different person for the ASRA Annual Regional Anesthesia Meeting in the Spring and the ASRA Annual Pain Medicine Meeting in the Fall.

ASRA Spring Meeting Representative:

Name: _____ Title: _____

Email address: _____ Phone: _____

Mailing Address (if different): _____

ASRA Fall Meeting Representative:

Same representative as for ASRA Spring

Or, if different representative than for ASRA Spring:

Name: _____ Title: _____

Email address: _____ Phone: _____

Mailing Address (if different from above): _____

It is mutually understood by the above named company and the Corporate Partner representative(s) of that company that the ASRA Spring and Fall Meeting programs are for scientific and educational purposes only. The acceptance of any company in the ASRA Corporate Partnership program does not imply ASRA support of that company's products or services, either directly or indirectly.

Corporate Partner Representative Signature _____

Date _____

ASRA Representative Signature _____

Date _____