

# Rehabilitation Oncology Advertising Order Form

## INSTRUCTIONS

Please complete this order form and fax or mail your payment to:

**Oncology Section, APTA, PO Box 327, Alexandria VA 22313.** Fax: 703/706-8575 Tel: 703/706-8564

Payment and ad copy should be submitted by the advertisement deadline. See below for ad submission instructions.

Advertiser: \_\_\_\_\_

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

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

Phone: (        ) \_\_\_\_\_

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

Fax: (        ) \_\_\_\_\_

Signature of Advertiser: \_\_\_\_\_ Date: \_\_\_\_\_

E-Mail: \_\_\_\_\_

## PRICING

CHECK THE APPROPRIATE SIZE, RATE, AND ISSUES(S). ALL RATES ARE NON-COMMISSIONABLE.

	<b>Size (Height x Width)</b>	<b>1x Insertion Rate (Per Issue)</b>	<b>3x Insertion Rate (Per Issue)</b>
Full page	10 x 7	_____ \$400	_____ \$350 x 3
1/2 page horizontal	5 x 7	_____ \$300	_____ \$250 x 3
1/4 page	5 x 3.5	_____ \$200	_____ \$150 x 3
1/8 page	2.5 x 3.5	_____ \$100	_____ \$75 x 3
<b>PREMIUM PAGES</b>			
Inside Front Cover	10 x 7	_____ \$650	_____ \$600 x 3
Inside Back Cover	10 x 7	_____ \$650	_____ \$600 x 3
Outside Back Cover	5 x 7	_____ \$650	_____ \$600 x 3
RUN AD IN FULL COLOR		_____ Add \$500 per insertion	
			<b>TOTAL: \$</b>

## 2008/2009 PUBLICATION SCHEDULE **AD SUBMISSION**

<b>Issue- projected mail month</b>	<b>Ad Deadline</b>
May	March 6
September	July 10
November	September 11

It is preferred that advertisements be submitted electronically on CD or Zip disc in either Macintosh or PC formats. If you are e-mailing your ad, send to: sklinski@orthopt.org. You may mail your ad to: **Sharon Klinski, Orthopaedics Section, 2920 East Avenue S, La Crosse, WI 54601-8231.** The ad should be in PDF format only. Files should be distilled with the Press Optimized setting in Acrobat Distiller or saved directly from the native program using PDF/X-1a or PDF/X-3. Images should be of adequate quality to allow output at 2,540 dpi and 150 lpi screens. NO ads will be accepted without a FAX copy of the ad sent to 608/788-3965.

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**Payment Type:**    VISA    MasterCard    American Express    Check (Payable to Oncology Section)

**Credit Card Number:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Name on Card:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Billing Address, if different from Shipping Address:** \_\_\_\_\_