



# Annual Dialysis Conference

presented by the *University of Missouri Division of Nephrology*

## 2018 DIALYSIS CONFERENCE PROGRAM ADVERTISING RATES

Handed out onsite to all conference attendees

### Advertisement Size Options



Two Page Spread  
17 X 11



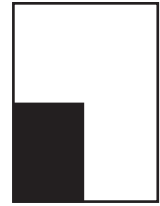
Full Page  
8 1/2 X 11



Half Page Horizontal  
8 1/2 X 5 1/2



Half Page Vertical  
4 X 11



Quarter Page  
4 X 5 1/2

**Note:** Trim size of program is 8 1/2 x 11

### Production Requirements

- Advertisements must be submitted as eps, tiff or pdf files and may be emailed to: schmidt@health.missouri.edu
- Software supported by the printer: Quark, PageMaker, InDesign, PhotoShop, Illustrator, Freehand, and Acrobat
- Trim Size: 8 1/2 X 11 inches  
Binding: Saddlestitched
- Questions concerning ad submission? Contact Karen Schmidt  
schmidt@health.missouri.edu

### Deadlines

Space and Payment Deadline: January 19, 2018

Artwork Submission Deadline: February 1, 2018

### Advertisement Size and Location- please mark your preference:

Ad Size	Rate	Dimensions (Width X Height)
<input type="checkbox"/> Two Page Spread	\$2,000	17 X 11 inches
<input type="checkbox"/> Full Page	\$1,500	8 1/2 X 11 inches
<input type="checkbox"/> 1/2 Page Horizontal / Vertical	\$900	8 1/2 X 5 1/2 inches / 4 X 11 inches
<input type="checkbox"/> 1/4 Page	\$450	4 X 5 1/2 inches

**Above locations do not include inside cover and facing page or back cover (premium positions), those locations are listed below.**

<input type="checkbox"/> Inside Front Cover	\$3,000	8 1/2 X 11 inches
<input type="checkbox"/> Inside Front Cover + Facing Page	\$4,500	17 X 11 inches
<input type="checkbox"/> Inside Back Cover	\$2,000	8 1/2 X 11 inches
<input type="checkbox"/> Inside Back Cover + Facing Page	\$3,500	17 X 11 inches
<input type="checkbox"/> Back Cover	\$3,000	8 1/2 X 11 inches

### Return this form with payment:

Dialysis Conference  
 Attn: Thom Pancella  
 1 Hospital Drive, DC018.00  
 Columbia, Missouri 65212  
 Phone: (573) 882-8792 • Fax: [573] 882=5666

Total Enclosed \_\_\_\_\_

Company Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City State ZIP \_\_\_\_\_

Phone \_\_\_\_\_

FAX \_\_\_\_\_

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

Date \_\_\_\_\_

### Method of Payment:

Check- If paying by check, make payable to  
Academy of Post Graduate Health Education,  
tax ID #43-1682002.

Visa  MasterCard  Discover  American Express

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

Card Holders Address \_\_\_\_\_

City State ZIP \_\_\_\_\_