

KAM Membership Label Request

Knoxville Academy of Medicine
115 Suburban Road * Knoxville, TN 37923
Phone: (865) 531-2766 * FAX: (865) 531-9027

Date Requested _____ Date Needed _____

(Please Print)

Requestor _____

Company _____

Phone _____ FAX _____

Address _____

Purpose of Mailing: _____

Your payment and a copy of the item being mailed must be attached to this completed form to be pre-approved by the Academy. Please allow 3 business days for the label request after approval. The Knoxville Academy of Medicine rents mailing labels to various organizations, which use them for different reasons. The Academy has developed price categories below. If the mailing is a physician announcement or medical practice news, the cost per set of labels is \$40.00 for a KAM member and \$100 for a non-member physician. Other prices are as follows: any medical or non-profit organization can rent mailing labels at a cost of \$125.00. These prices apply only if the mailing is non-political and not-for-profit. For a non-medical or for-profit organization, the rental price is \$250.00. *Please attach a sample of the mailing to this form.*

The Knoxville Academy of Medicine owns the mailing labels that are requested by your organization. The fee you pay covers the rental of these mailing labels for a single use. By signing the contract, you agree not to reproduce these labels. The labels may be picked up at our office located at 115 Suburban Road or if you prefer the labels to be mailed, then add the rental fee plus a shipping and handling fee of \$3.00 per set of labels. Make check payable to: **Knoxville Academy of Medicine.**

Please sign below stating that you agree to the terms of this contract.

Signature Date

What addresses are being requested?

Standard Categories:

- Active
- Emeritus/Retired
- Resident

Rental fees cover use of labels one (1) time
KAM Member - \$40.00
Non-Member physician - \$100.00
Any medical or non-profit organization - \$125.00
Any other for-profit organization - \$250.00
Shipping/Handling Fee \$3.00 (if applicable)

Special Sorts (Additional \$10.00 per sort)

- Practice
- Age Age Group _____
- Specialty Category _____
- Other _____

Amount Paid \$ _____
_____ Credit Card (see below) _____ Check

Sorted By: (Please choose only one)

- Zip Code
- Alphabetical

KAM Office/Approved by:

Payment by Credit Card

Please check one: Visa MasterCard American Express

TOTAL \$ _____

Credit Card # _____ - _____ - _____ - _____

Expiration Date _____ / _____

Billing Zip Code _____

Personal Card

Print Name as it appears on Credit Card

Corporate Card*

**If Corporate, name of corporation*