



ASSOCIATION of PEDIATRIC
HEMATOLOGY/ONCOLOGY NURSES

Commercially Supported Symposia
Application Form
34th Annual Meeting
October 14-16, 2010
Hyatt Regency Minneapolis

All information must be completed and included on this application. Each application must include the following information to be considered: (please attach separately)

- Proposed title of program
- Needs assessment
- Purpose
- Objectives
- Description
- Teaching/Learning methods
- Proposed speakers (including academic degrees, institution, city and state)
- Synopsis of 50 words or less for use in APHON conference brochure

TYPE OF FORUM PREFERENCE

- Breakfast
- Luncheon
- Dinner

Note that every effort will be made to accommodate your preference; however, no guarantees can be made. Additionally, any or all of the preferred times may be concurrent with other symposium.

GRANT PROVIDER

Company Name _____
 Address _____
 City, State _____ Zip/Postal Code _____ Country _____
 Telephone _____ Fax _____ E-mail Address _____
 Direct future correspondence to _____ Title _____
 Telephone _____ Fax _____ E-mail Address _____
 Person authorizing request _____ Title _____
 Signature _____

THIRD PARTY COMMUNICATION COMPANY (IF APPLICABLE)

Company Name _____
 Address _____
 City, State _____ Zip/Postal Code _____ Country _____
 Telephone _____ Fax _____ E-mail Address _____
 Direct future correspondence to _____ Title _____
 Telephone _____ Fax _____ E-mail Address _____
 Person authorizing request _____ Title _____
 Signature _____

We certify that the information provided is accurate and complete, and that we agree to follow the APHON guidelines for Commercially Supported Symposia.

Signature _____ Date _____

Contact: Terri Berkowitz, Sales and Corporate Relations Manager
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