

# NCMS/SCMS NEWSLETTER INSERTION AND ONLINE CLASSIFIED ORDER FORM

To place a classified ad in the NCMS/SCMS Update, our monthly newsletter, and in the Classifieds section of our website, please complete the form below and mail it with credit card information or check payable to NCMS/SCMS.

1. Name of Advertiser:  Agency:

2. Billing Mailing Address:  City:  State:  Zip:

3. Contact Person:  Title:  Phone:

4. Ad to be run beginning month of:  (  number of times, or until what month  ).

5. Signature: \_\_\_\_\_ date:

### NCMS/SCMS Members:

Annual membership entitles physician members to one ad for two issues of the Update and two months online at no charge. When the free period has expired, the advertisement will be removed unless notification and pre-payment is received. Monthly automatic billing is available. Please contact SCMS/NCMS with questions at 707-255-3622 or [exec@ncms.com](mailto:exec@ncms.com). In order to request an ad placement, please complete this form and include payment information below. All cancellations must be received at least 15 days prior to the start of the month in which the ad will run.

### Non-NCMS/SCMS Members:

Non-NCMS/SCMS members will be charged a fee of \$1/word for one ad to be placed in two issues of the Update, the monthly newsletter, and on the website for two months. Billing information and pre-payment is required at the time that the advertisement is placed. All ads are subject to approval by NCMS/SCMS. For online classified advertising please submit any artwork for inclusion with the listing. Please include payment information below. All cancellations must be received at least 15 days prior to the start of the month in which the ad will run.

### Pay by Check:

You may mail this completed form and a check payable to NCMS/SCMS, 3273 Claremont Way, Suite 205, Napa, CA 94558.

### Pay by Credit Card:

Please fill out the form below and submit via email to [exec@ncms.com](mailto:exec@ncms.com), by mail to NCMS/SCMS, 3273 Claremont Way, Suite 205, Napa, CA 94558, or by fax to 707-255-2544.

American Express     Master Card     Visa

Card#:  Exp Date:  Security Code:

Card Holder Name:

Billing Address:  City:  State:  Zip:

Card Holder's Signature: