473 South St. West, Unit 2
Raynham, MA 02767
Tel: (508) 967-9077

SPONSORSHIP AGREEMENT

Dentist / Dental Office Name: _____

Business Address: _____

City, State, Zip_____

Company Name:_____

Sponsor Representative: _____

Business Phone: _____ Business Fax: _____

Sponsor E-mail: _____

Company Website: _____

Sponsorship Level: (check one)

___Premium Sponsor	Total: $3,995.00
___Gold Sponsor	Total: $1,799.00
___Silver Sponsor	Total: $599.00

METHOD OF PAYMENT (check one)

Credit Card: ____ MasterCard ____VISA ____American Express ____Discover ____Square Invoice

Card Number: _____-_____-_____-_____

Expiration Date:____/_____

Name of Card: _____

Signature: _____

* Sponsor must provide a pdf or .jpeg file of company logo * Sponsor/Membership will be good for (1) year.

Please Note: Your credit card will be charged the full amount (listed under Sponsorship Level)

FAX BACK TO: (774) 272-9411 or email to: eastcoastdentaltech@gmail.com

*You will also receive a receipt of this agreement.

THANK YOU! FROM EAST COAST DENTAL TECH