**AACR**
American Association
for Cancer Research

# AACR ANNUAL MEETING 2020

SAN DIEGO, CA | APRIL 24-29
San Diego Convention Center

# AACR SATELLITE EDUCATIONAL SYMPOSIA APPLICATION

Application submission deadline: **January 10, 2020**
Applications will not be processed without deposit.

## Applicant Information

Program Title

Program Director Name

CME Provider

Sponsoring Organizer Company Name

Contact Name

Title

Address

City                                    State/Province

Zip/Postal Code              Country

Email Address

Phone

Industry Supporter Company Name

Address

City                                    State/Province

Zip/Postal Code              Country

## Space Request (Every effort will be made to accommodate requests.)

**Preferred Dates**
(Evening slots only; suggested time 6:30 p.m.–10:00 p.m.)
Please rank your preferred dates from 1-4 with 1 being the highest.

Saturday, April 25 _____       Sunday, April 26 _____

Monday, April 27 _____       Tuesday, April 28 _____

**Anticipated size of audience:** _____

**Food service planned:**    ❑ Yes        ❑ No

If yes, type of service (i.e. reception, buffet, plated dinner):

_____

**Set-up requested:**
❑ Theater    ❑ Conference    ❑ Classroom
❑ Reception    ❑ Rounds
❑ Other _____

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## Proposals Must Also Include the Following:

❑ Target Audience       ❑ Program Abstract
❑ Professional Practice Gaps and Needs Assessment
❑ Learning Objectives
❑ Names and credentials of proposed faculty
❑ General Plan for marketing the symposium
❑ Non-refundable deposit of $5,000 (total fee: $75,000)
   **NOTE: If accepted, final payment is due by February 12, 2020.**

## Disclaimer and Signature

By submitting this application, the organizer acknowledges understanding of the AACR's guidelines and restrictions regarding Satellite Educational Symposia and agrees to abide by them.

_____
Signature                                              Date

## Payment Information

❑ Check Payment       ❑ Credit Card Payment
                          ❑ Visa        ❑ MasterCard        ❑ American Express

_____
Credit Card Number              CSC/CVV#          Expiration Date

_____
Name on Card

_____
Authorized Signature

_____
Billing Address (street)

_____
Billing Address (city, state, zip)

## Submit this form along with all materials and deposit by January 10, 2020 to:

**Mail:** AACR
     Attn: Lisa McGlashen
     615 Chestnut Street, 17th Floor
     Philadelphia, PA 19106

**Email:** lisa.mcglashen@aacr.org

**Fax:** 267-825-9537