



**22 June 2023**  
**VenueSix 10**  
**Sponsorship**



**2023 ANNUAL MEETING & HEALTHCARE AWARDS**  
**INSTITUTE OF MEDICINE OF CHICAGO**



# INSTITUTE OF MEDICINE OF CHICAGO

## 2023 Annual Meeting & Healthcare Awards

<b>SPONSOR LEVEL</b>	<b>LEADER</b> \$100K <i>Limit One</i>	<b>BENEFACTOR</b> \$50K <i>Limit Three</i>	<b>PARTNER</b> \$25K	<b>FRIEND</b> \$10K	<b>INNOVATOR &amp; VIRTUAL SESSIONS</b> \$7,500	<b>SUPPORTER</b> \$5K	<b>COLLEAGUE</b> \$1K
20 Tickets	•						
10 Tickets		•					
6 Tickets			•				
4 Tickets				•			
Multi-Media Recognition(Full Year)	•						
Introduce Main Speaker for Grand Convening	•						
Name on Summary Report	•	•					
Website Recognition–Name of Company	•	•	•	•	•	•	•
Recognition (PPT) Grand Convening	•	•	•	•			
Newsletter	•	•	•	•	•	•	•
Recognized in News Releases	•	•	•	•	•	•	•
Event Signage	•	•	•	•	•	•	•
After Convening Networking Recognition	•	•	•				
Program Booklet & Brochures	•	•	•	•	•		
Introduce Sessions Speaker					•		
Full page ad	•	•					
Ad ½ page			•	•			
Ad ¼ page					•		



## 2023 Annual Meeting & Healthcare Awards

### Institute of Medicine of Chicago Sponsorship Contract

**Yes! I would like to become a sponsor**

Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Website \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Direct Phone \_\_\_\_\_ Email \_\_\_\_\_

**Sponsorship Level** (Please choose one)

**Leader** \$100,000 \_\_\_      **Benefactor** \$50,000 \_\_\_      **Partner** \$25,000 \_\_\_

**Friend** \$10,000 \_\_\_      **Innovator +/-or Virtual Sessions** \$7,500 \_\_\_

**Supporter** \$5,000 \_\_\_      **Colleague** \$1,000 \_\_\_      **Table of Eight** \$3000 \_\_\_

Identify session number, if applicable \_\_\_\_\_

Other (briefly describe) \_\_\_\_\_

### Payment Information

\_\_\_ Check enclosed, payable to: Institute of Medicine of Chicago

Credit Card: \_\_\_ American Express \_\_\_ Master Card \_\_\_ Visa \_\_\_ Discover

Credit Card # \_\_\_\_\_ Exp. \_\_\_\_/\_\_\_\_ Security Code \_\_\_\_\_

(3-4 digits on the back of the card if using Master Card or Visa; or on the front of the card if using American Express.)

Name on Card \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Zip \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please print form and complete all information.**

Send your completed form to [iomcstaff@iomc.org](mailto:iomcstaff@iomc.org) or mail your completed form and check to the Institute of Medicine of Chicago, P.O. Box 11793, Chicago, IL 60611. Contact us at 312.709.2685 or send a message to [iomcstaff@iomc.org](mailto:iomcstaff@iomc.org) if you have any questions.