



Application forms are due by February 16, 2022, to be included in the online conference schedule. To be considered, each application must be complete and include the following information:

- Proposed title of program, length of each presentation, proposed faculty names (if known, including academic degrees, institution, city, and state), learning objectives, and ACCME accreditation statements (if appropriate)
- Preferred day and time
- Synopsis of the program of 50 words or less for use by ASPHO evaluating committee

TYPE OF FORUM PREFERENCE: CME  NON-CME

<u>Morning Symposia</u>	<u>Afternoon Symposia</u>	<u>Evening Symposia</u>
Wednesday May 4 <sup>th</sup>	Wednesday May 4 <sup>th</sup>	Wednesday May 4 <sup>th</sup>
Thursday May 5 <sup>th</sup>	Thursday May 5 <sup>th</sup>	Thursday May 5 <sup>th</sup>
Friday May 6 <sup>th</sup>	Friday May 6 <sup>th</sup>	
Saturday May 7 <sup>th</sup>		

\*\$25k-\$40k, 60-90 minutes depending on day and time  
 \*Contact Michele Gallas at mgallas@aspho.org for details regarding day/time

\*One hematology and one oncology morning and afternoon program available per noted days. Times will be assigned when approved and are subject to change.

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

**SPONSORING ORGANIZATION**

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 \_\_\_\_\_

**CME 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 \_\_\_\_\_

We certify that the information provided is accurate and complete, and that we agree to follow the ASPHO [guidelines for Satellite Symposia](#).

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

Return this form to: Michele Gallas, Senior Sales Manager  
 847-375-4853 | Email: [mgallas@aspho.org](mailto:mgallas@aspho.org)  
 American Society of Pediatric Hematology/Oncology  
 8735 W. Higgins Road, Suite 300, Chicago, IL 60631