

**ASCENSION ST. JOHN HOSPITAL
SPEAKER AGREEMENT & COMMITMENT FORM**

Educational Activity _____ Date _____

Name (Printed) _____ Degrees _____ DOB: _____

Honoraria check to be made out to (if applicable) _____
(only if different than above)

S. S. Number/Tax I.D. Number _____ Honorarium amount _____

Institutional Affiliation & Dept _____
(Necessary for Honorarium) *(if applicable)*

Academic Titles _____

Work Address _____
(Business Name, Suite, Street, City, State, Zip Code)

Work Phone () _____ E-mail Address _____

Fax Number () _____

Home Address _____

Have you been a presenter for Ascension St. John before? Yes or No

Hotel Reservations needed: yes or no Date needed: _____

Standard AV Equipment will be available -please notify us if additional setup required

___ I will present using Powerpoint or google slides and email my presentation to Nancy.DeRita@Ascension.org
at least two weeks before symposium date.

Speaker Recording Authorization *(audio and/or videotape)* Please check the appropriate box to give us
authorization to record your presentation in the interest of science and furtherance of healthcare education.

___ I hereby authorize Ascension St. John Hospital to have its assigned representative record my presentation at
the above listed conference. I understand that I am giving Ascension St. John Hospital the rights to
duplicate my presentation and place it in the hospital library for physicians and medical professionals to
check out as well as on our Medical Education website.

___ I hereby refuse to authorize Ascension St. John Hospital to have its assigned representative record the above
presentation

**By signing this speaker agreement, I also certify that I am not receiving any additional remuneration
directly from any commercial source.**

Signature _____ Date _____

Please send, fax or email to: Ascension St. John Hospital
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