

Commercial Label Request Form

DEADLINE: JANUARY 31

Direct mail-approved is defined as those current CDS members who have not opted out of commercial mailings.

CDS MEMBERSHIP LIST CATEGORIES

Quantities subject to change. Direct mail-approved.

- Midwinter Meeting Dentist plus CDS Members
- CDS Domestic Dentists
- CDS Illinois Dentists
- CDS Non-Illinois Dentists (USA)
- CDS International Dentists

FORMATS

Dentist names only. Does not include phone/fax numbers or e-mail addresses.

- Electronic files (Format: Comma-Separated Value-CSV/Excel)
- Lists: Alphabetical list of dentists with office addresses

NOTE: CDS does not include names of dentists who object to being included in the rental of commercial mailing lists. Only non-dentists may purchase mailing lists.

COST

Set-up fee: \$200 (non-refundable), Price: \$80 per 1,000 names (Price rounds up to the nearest 1,000 names).

PROCEDURE

- The request must be submitted in writing on official company letterhead.
- Included in the request is the purpose of the label request and a copy of the mailer (postcard, flier etc.).
- Once the written request is received, it will take approximately 7-10 business days to process and fulfill.
- Rendering of mailer must be approved by CDS prior to delivery of mailing list.
- If requesting an electronic file, the written request must state the following:
 1. The electronic list will be used one time only.
 2. The electronic list will not be shared with any other organization/company
- Labels will not be rented to promote any program or seminar held during the official dates of the Midwinter Meeting.
- Payment in full must be included with the written request (Payment can be made via check, money order, Visa or Mastercard)

PAYMENT

CDS accepts Visa or Mastercard only.

Fax completed form to 312.836.7339, or mail to Chicago Dental Society, 401 N. Michigan Avenue, Suite 200, Chicago, IL 60611.

Contact Erin Underwood at 312.836.7315 or eunderwood@cds.org.

Company name: _____

Contact person/title: _____

Address: _____

City/state or country/zip or postal code: _____

Phone: _____ Fax: _____

E-mail (required): _____

Date of request: _____ Date data needed: _____

PAYMENT METHOD: Visa Mastercard Amount: _____

Cardholder's name (please print): _____

Cardholder's billing address: _____

Card number: _____ Expiration date: _____

Cardholder's signature: _____



Chicago Dental Society

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