Examiner Classifieds

CLASSIFIED ADVERTISING FORM

Name _____

Address _____

Work number (if applicable) ( ) _____

Home phone ( ) _____

In case we need to contact you. These numbers will not appear in the ad.

Category of ad (leave blank if unsure): _____

AD COPY (one word per line; phone numbers MUST include the area code):

.25	.50	.75
1.00	1.25	1.50
1.75	2.00	2.25
2.50	2.75	3.00
3.25	3.50	3.75
4.00	4.25	4.50
4.75	5.00	5.25
5.50	5.75	6.00
6.25	6.50	6.75
7.00	7.25	7.50
7.75	8.00	8.25
8.50	8.75	9.00

(Copy this form or continue on additional sheet if more space needed.)

Send this form with payment to:

AUGUSTA MEDICAL EXAMINER, PO BOX 397, AUGUSTA, GA 30903-0397

Total ad cost by number of words as shown above: $ _____

Multiply by number of times ad to run: x _____

Total submitted: $ _____

The Augusta Medical Examiner publishes on the 1st and 15th of every month. Your ad should reach us no later than 5 days prior to our publication date.