

# REGISTRATION FORM

Cost: **\$285** for Dentists / **\$185** for RDHs and Aux. / U.S. Funds **\$145** for RDHs + Aux. in Attendance w/ Dr. - *must register together*  
*Late Fee: Add \$10/registrant if after Friday, July 20, 2018.*

**Refunds / Cancellation Dates:**  
Please see policy above. By registering, you agree to the Terms of Policy.

**PLEASE INDICATE DATE YOU WILL BE ATTENDING:**

**7/27/18 • Tempe, AZ**

**7/28/18 • Las Vegas, NV**

*Please note when providing your email address, you are consenting to being added to our mailing list and will receive notifications of upcoming seminars in your area only. (We do not share or sell any information given to us).*  
 *No, do not add my email to your database- only send email communication regarding this seminar (payment receipts & last minute notifications).*

Please *clearly* enter your name as it appears with the State Board of Dental Examiners for your CE credit.




	<i>First Name</i>	<i>M.I.</i>	<i>Last Name</i>	
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA EFDA Off. Adm. Email _____ <i>(for credit card receipt &amp; last-minute course changes or notifications)</i>
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Confirmations will be mailed to the address below: *Home or Office of* \_\_\_\_\_ Telephone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

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City / State / Zip Code \_\_\_\_\_ Fax \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

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<input type="checkbox"/>  3 digit CVV: _____	<input type="checkbox"/>  3 digit CVV: _____	<input type="checkbox"/>  4 digit CVV: _____	<input type="checkbox"/>  3 digit CVV: _____
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Please mail or fax registration form with payment to:  
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