

REGISTRATION FORM

Cost: **\$285** for Dentists / **\$185** for RDHs and Aux. / U.S. Funds
\$145 for Staff attending w/ Dr. *(see yellow starburst above for details)*

Late Fee: Add \$10/registrant if after **Friday, September 28, 2018.**

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

	First Name	M.I.	Last Name			
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm.	Email	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm.	Email	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm.	Email	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm.	Email	<input type="text"/>

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

PLEASE INDICATE DATE YOU WILL BE ATTENDING:

10/5/18 • Bettendorf, IA **10/6/18 • Iowa City, IA**

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).

(for credit card receipt & last-minute course changes or notifications)

Confirmations will be mailed to the address below: Home or Office of _____ Telephone _____ (____) _____

Home or Office Mailing Address _____ Cell _____ (____) _____

City / State / Zip Code _____ Fax _____ (____) _____

Payment Options: Check (make payable to: *Concord Dental & Medical Seminars*)

 3 digit CVV: _____
  3 digit CVV: _____
  4 digit CVV: _____
  3 digit CVV: _____

Card #: _____ Exp. Date: _____ / _____
Month Year

Cardholder's Name: _____

Signature: _____

Cardholder's Billing Address: _____
 Same as above



Please mail or fax registration form with payment to:

Concord Dental & Medical Seminars, LLC

PO Box 700 • Epsom, NH 03234-0700

(603) 736-9200 • Fax: (603) 736-9208

or register online at:

www.concordseminars.com

For Office Use Only

Date Rec'd _____ Amt. \$ _____ Check # _____



Confirm Out _____