

# REGISTRATION FORM

Cost: **\$285** for Dentists / **\$185** for RDHs & Aux. / U.S. Funds **\$145** for RDHs & Aux. in Attendance w/ Dr. *(must register together)*

*Late Fee:* Add \$10/registrant if after **April 6, 2018**.

Please *clearly* enter your full name as it appears w/ State Board 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 _____
				<i>(for credit card receipt &amp; last-minute course changes or notifications)</i>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm. Email _____
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm. Email _____
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA Off. Adm. Email _____

Home or Office of \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Home or Office Mailing Address \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

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

### Payment Options:

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*Refunds / Cancellation Dates:*  
**PLEASE SEE POLICY ABOVE**  
**FOR ALL DETAILS.**

### I WILL BE ATTENDING:

**4/13/18 • Columbus, OH**     **4/14/18 • Cincinnati, OH**

*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 mail or fax registration form with payment to:



**Concord Dental & Medical Seminars, LLC**  
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