

# 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 **February 16, 2018**.

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

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

PLEASE INDICATE DATE YOU WILL BE ATTENDING:

**2/24/18 • Baltimore, MD**

**2/25/18 • Harrisburg, PA**

*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).*


	<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	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 _____

*Confirmations will be mailed to the address below:* Home or Office of \_\_\_\_\_ Telephone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

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

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

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Please mail or fax registration form with payment to:  
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