

# REGISTRATION FORM

Cost: **\$285** for Dentists / **\$185** for RDHs and Aux. / U.S. Funds **\$145** for Staff attending w/ Dr. *(details in yellow burst on reverse side)*

Late Fee: Add \$10/registrant if after **November 30, 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 side.  
By registering, you agree to the  
Terms of Policy.

PLEASE INDICATE DATE  **12/7/18** • **San Antonio, TX**  
YOU WANT TO ATTEND:  **12/8/18** • **Dallas, TX**

*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 EFDA 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 EFDA Off. Adm. Email _____
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA EFDA Off. Adm. Email _____
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH RDA CDA EFDA Off. Adm. Email _____

*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*)

<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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Date Rec'd _____	Amt. \$ _____
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