

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 **March 2, 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 YOU WILL BE ATTENDING:

3/9/18 • Austin, TX

3/10/18 • Houston, 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).

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

(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*)

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

Cardholder's Name: _____

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 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:**
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For Office Use Only
 Date Rec'd _____ Amt. \$ _____ Check # _____



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