

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: **Friday, October 26.**

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

I WILL BE ATTENDING: **11/4/18 • Rockford, IL**

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

	<i>First Name</i>	<i>M.I.</i>	<i>Last Name</i>		
1.	<input style="width: 100%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>	DDS DMD RDH EFDA RDA CDA Off. Adm. Email	_____
					<i>(for credit card receipt & last-minute course changes or notifications)</i>
2.	<input style="width: 100%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>	DDS DMD RDH EFDA RDA CDA Off. Adm. Email	_____
3.	<input style="width: 100%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>	DDS DMD RDH EFDA RDA CDA Off. Adm. Email	_____
4.	<input style="width: 100%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>	DDS DMD RDH EFDA RDA CDA 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 _____ (____) _____

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<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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