

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, September 7, 2018.**

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:

9/15/18 • Omaha, NE

9/16/18 • Sioux Falls, SD

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 type="text"/> | <input type="text"/> | <input type="text"/> | DDS | DMD | RDH | RDA | CDA | Off. Adm. | Email <input type="text"/> |
| 2. | <input type="text"/> | <input type="text"/> | <input type="text"/> | DDS | DMD | RDH | RDA | CDA | Off. Adm. | Email <input type="text"/> |
| 3. | <input type="text"/> | <input type="text"/> | <input type="text"/> | DDS | DMD | RDH | RDA | CDA | Off. Adm. | Email <input type="text"/> |
| 4. | <input type="text"/> | <input type="text"/> | <input type="text"/> | DDS | DMD | RDH | RDA | CDA | Off. Adm. | Email <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*)

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

Cardholder's Name: _____

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Please mail or fax registration form with payment to:


Concord Dental & Medical Seminars, LLC
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