

# 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: **9/14 (PA date) or 9/28 (NY date)**.

**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:**  
 **9/22/18 • Wilkes-Barre, PA**     **10/6/18 • White Plains, NY**

*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 _____
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 _____

*(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:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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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:**  
**[www.concordseminars.com](http://www.concordseminars.com)**

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



Confirm Out \_\_\_\_\_