

REGISTRATION FORM

Cost: **\$285** for Dentists / **\$185** for RDHs and Aux. / U.S. Funds **\$145** for RDHs + Aux. in Attendance w/ Dr. - *see details above*

Late Fee: Add \$10/registrant if after **October 11, 2019**.

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

| | First Name | M.I. | Last Name | |
|----|----------------------|----------------------|----------------------|---|
| 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 _____ |

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

I/WE WILL BE ATTENDING:

10/18/19 • Grand Rapids, MI

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).

(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*) **Online:** *www.concordseminars.com*

| | | | |
|--|---|---|---|
| <input type="checkbox"/>  3 digit CVV: | <input type="checkbox"/>  3 digit CVV: | <input type="checkbox"/>  4 digit CVV: | <input type="checkbox"/>  3 digit CVV: |
|--|---|---|---|

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

Cardholder's Name: _____

Signature: _____

Cardholder's Billing Address: _____
 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:

www.concordseminars.com

For Office Use Only

Date Rec'd _____ Amt. \$ _____ Check # _____



Confirm Out _____