

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 **January 12, 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 FOR ALL DETAILS.*

PLEASE INDICATE DATE YOU WILL BE ATTENDING:

1/19/18 • E. Lansing, MI **1/20/18 • Bay City, 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).

	<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 IPDH RDA CDA Off. Adm. Email _____ <i>(for credit card receipt & last-minute course changes or notifications)</i>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH IPDH RDA CDA Off. Adm. Email _____
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH IPDH RDA CDA Off. Adm. Email _____
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	DDS DMD RDH IPDH 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 _____ (_____) _____

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: _____
--	---	---	---

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 _____