

REGISTRATION FORM

Cost: **\$310** for Dentists / **\$205** for RDHs and Aux. / U.S. Funds
\$180 for RDHs + Aux. registering & attending w/ Dentist
Late Fee: Add \$15/registrant if after **Friday, February 7, 2025**

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

I WILL BE ATTENDING:

- 2/14/25 • Lancaster, PA**
- 2/15/25 • Hagerstown, MD**

Please provide a unique email address for all registrants as we will send confirmations, payment receipts and last minute course notifications to all attendees.
We do not share or sell any information given to us.

Email and/or Text me for sales, discounts and upcoming seminars.

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	DDS	DMD	RDH	RDA	CDA	EFDA	Off.	Adm.	Email
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Home or Office of _____ Telephone (____) _____

Home or Office Mailing Address _____ Cell (____) _____

City / State / Zip Code _____

(3) WAYS TO REGISTER:

- Mail form with payment to:** **Concord Dental Seminars**
PO Box 700
Epsom, NH 03234-0700
- Scan QR Code to register online or visit:**
www.concordseminars.com
- By phone:**
(603) 736-9200



For Office Use Only:

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



Confirm Out _____

Payment Options: Check (make payable to: *Concord Dental & Medical Seminars*) **Online:** www.concordseminars.com



3 digit CVV or 4 for Amex: **Please ensure to provide CVV and expiration date for credit card.**

Card #: _____ Exp. Date: ____ / ____

Cardholder's Name: _____

Signature: _____

Cardholder's Billing Address: _____
 Same as above