

# REGISTRATION FORM

Cost: **\$310** for Dentists / **\$205** for RDHs and Aux. / U.S. Funds  
**\$180** for RDHs + Aux. registering & attending w/ Dentist

**Early Bird Rate:** Deduct \$10/registrant if before **3/1**; **Late Fee:** Add \$15/registrant if after **4/18**

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

## I WILL BE ATTENDING:

- 4/25/25 • Springfield, IL**
- 4/26/25 • St. Louis, MO**

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

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.**

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](http://www.concordseminars.com)
- By phone:**  
**(603) 736-9200**



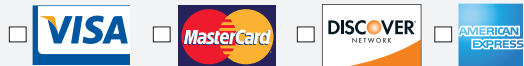
### For Office Use Only:

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



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

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