REGISTRATION FORM

(one form per registrant)

Name:____________________ ☐ Dentist ☐ Hygienist ☐ Assistant ☐ Staff ☐ Student

Address:____________________ Phone: __________

City:__________ State:__________ Zip: __________

E-mail Address:____________________

Dental School Attended & Year of Graduation:____________________

(Discounts: If you graduated from Marquette in the last 5 years or you are a dentist 65 years of age or older, you are eligible for a discount. Subtract 20% from your total. Discounts are not vallid for hands on courses.)

Please enroll me in the following course(s):

Course:____________________ Date:__________ Fee:__________

Course:____________________ Date:__________ Fee:__________

Course:____________________ Date:__________ Fee:__________

Payment: ☐ I have enclosed a check (payable to Marquette Unviersity School of Dentistry)

☐ Please charge my: ☐ Visa ☐ MasterCard

Card Number:____________________ Exp Date:__________

Signature:____________________

Phone: 414-288-3093

Mail To: Marquette University School of Dentistry, Continuing Education Office

P.O. Box 1881, Milwaukee, WI 53201

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