

REGISTRATION FORM

(One form per registrant)

Name: _____ Dentist Hygienist Assistant Staff Student
Address: _____ Daytime Phone: _____ Fax: _____
City: _____ State: _____ Zip Code: _____
E-mail Address: _____
Dental School Attended: _____ Year of Graduation: _____

Please enroll me in the following course(s):

Course: _____ Date: _____ Fee: _____
Course: _____ Date: _____ Fee: _____
Course: _____ Date: _____ Fee: _____

I wish to register as a Marquette School of Dentistry faculty member or student. *(Space Available Basis)*
Department: _____



If you graduated from Marquette in the last five 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 valid on CE trips.

I have enclosed a check (payable to: **Marquette University School of Dentistry**)
 Please charge my: Visa MasterCard Card Number _____
Expiration Date _____ Signature _____

REGISTER BY:	
MAIL	Marquette University School of Dentistry c/o Continuing Education Registration P.O. Box 1881 Milwaukee, WI 53201-1881
PHONE	414-288-3093
FAX	414-288-8354
ONLINE	http://www.marquette.edu/dentistry/ce/reg.shtml



A full refund will be issued with notification at least two weeks prior to the date of the course. Cancellations received within two weeks prior to the start date will receive a full refund less a \$25 cancellation fee. The School of Dentistry reserves the right to cancel a course due to low enrollment or unforeseen emergencies. In the event of a cancellation, all registrants will be notified as quickly as possible.