REGISTRATION FORM

(one form per registrant)

Name:________________________________ ☐ Dentist ☐ Hygienist ☐ Assistant ☐ Staff ☐ Student
Address:____ Phone:____________________
City:____________________________ State:__________________ Zip:__________________
E-mail AddDate: Fee: 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

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:____

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