

SDDS Course Registration Form

1. General Information

LAST NAME

FIRST NAME

BILLING ADDRESS

APT./SUITE

CITY

STATE

ZIPCODE

Phone: _____ ADA Number: _____ E-mail: _____

2. Registration

If registering staff, please indicate name(s): _____

COURSE NUMBER	TITLE	DATE	TUITION

3. Payment *(Make checks payable to Second District Dental Society)*

Check or Money Order enclosed Voucher

Credit Card: MasterCard Visa American Express

Credit Card Number: _____ Expiration Date: ____/____

CVV/CVC Code: _____

(The three/four-digit number located on front of card or on back of card on or above signature line)

Cardholder Signature: _____

Mail or fax completed form to:

Second District Dental Society
111 Fort Greene Place
Brooklyn, NY 11217
Phone: (718) 522-3939
Fax: (718) 797-4335