SDDS

COURSE REGISTRATION FORM

1. GENERAL INFORMATION

LAST NAME _____ FIRST NAME _____

BILLING ADDRESS _____ APT./SUITE _____

CITY _____ STATE _____ ZIPCODE _____

Phone Number: _____ ADA Number: _____

E-mail: _____ Kosher/Vegetarian? _____

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 (Debit cards not eligible): ○ MasterCard ○ Visa ○ American Express

Credit Card Number: _____ Expiration Date: ____/____

CVV/CVC Code: _____
(The three/four-digit number located on front/back of card)

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