SEMINAR REGISTRATION

NAME:

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DEGREE: DDS DMD
DENTAL SCHOOL: ______________________________
TYPE OF PRACTICE: ________________________ YEAR OF GRADUATION: ______
OFFICE ADDRESS:

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PHONE: ( ) - FAX: ( ) -

REGISTRATION DATES

Session 1 - May 15-16, 2009
Session 1 - July 17-18, 2009
Session 1 - August 28-29, 2009
Session 1 - October 30-31, 2009

PAYMENT OPTIONS

I have enclosed a check payable to CalAid.
Please charge tuition(s) ($1,995.00 per session) to my credit card.

VISA MASTERCARD AMERICAN EXPRESS DISCOVER CARD

CARD #: ______________________________ SECURITY CODE: _________

EXP. DATE: ___/___/___ SIGNATURE: ________________________________

REGISTRATION BY FAX:
Please fax the completed registration form with payment by credit card to 949-489-2764.

REGISTRATION BY MAIL:
Please mail a copy of the completed registration form along with your check to:
CalAid, P.O. Box 4076, Dana Point, CA 92629-9998

For more information or questions, please call TOLL FREE: 1-800-255-2043

All cancellations must be received at least 30 days prior to the course date to receive a full refund of your tuition. Cancellations received less than 30 days prior to the course date shall forfeit the $500 deposit. A $150 administrative fee will be charged for each cancellation against any amounts refunded. California Academy of Implant Dentistry reserves the right to cancel any program dates at any time due to insufficient registration and/or attendance. When possible, registrants will be notified at least one month prior to the course date if a program is cancelled or rescheduled. In no event will CalAid be responsible for any travel or other expenses incurred by a registrant.

registration