REGISTRATION FORM

(one form per registrant)

Name:_____ ☐ Dentist ☐ Hygienist ☐ Assistant ☐ Staff ☐ Student

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

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 University School of Dentistry)

☐ Please charge my: ☐ Visa ☐ MasterCard

Card Number:_____ Exp Date:_____ CVV:_____

Signature:_____

Phone: 414-288-3093

Mail To: Marquette University School of Dentistry, Continuing Education Office

P.O. Box 1881, Milwaukee, WI 53201

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