UNIVERSITY OF DETROIT MERCY

SCHOOL OF DENTISTRY
Institute for Advanced Continuing Dental Education

Course Registration Form

Please use one form per course, per registrant.

ALL FIELDS REQUIRED

Course Information:

Course Name: _____

Course Number: _____ **Course Date(s):** _____

Registrant Information:

Name:_____ ☐ **D.D.S.** ☐ **D.M.D** ☐ **R.D.H.** ☐ **R.D.A.** ☐ **Other**_____

Preferred Address: ☐ Business ☐ Home

Street:_____

City, State, Zip:_____

Phone: _____ **e-mail**:_____

Professional School Attended: _____

Year of Graduation & Degree:_____**Specialty**: _____

Payment Information:

Check: Amount: $_____ Make payable to: University of Detroit Mercy – Dental CE

Credit Card: ☐ Visa ☐ MasterCard **Name on Card**: _____

Credit Card Number: _____ **Expiration Date**: _____

Amount: $ _____ **Signature**: _____

Please return completed registration form to:

University of Detroit Mercy – School of Dentistry
Institute for Advanced Continuing Dental Education
2700 Martin Luther King Jr. Blvd.
Detroit MI, 48208-2576

e-mail: dentalce@udmercy.edu
Phone: 313-494-6626
Fax: 313-494-6844