

REGISTRATION FORM

Name		Title
Address		
City	State	Zip Code
Telephone	Fax	
Email	Type of Practice	
Dental School Graduated From		Year
Course	Dates	Fee
Course	Dates	Fee
Course	Dates	Fee

*** For Radiology please choose your clinic***

For enrollment, please complete the registration form and mail along with the full tuition for each course. Make checks payable to BUGSDM; or if you prefer to charge the tuition, complete the required credit card information.

Please Charge To:

Mastercard

Visa

Discover

Account #	Expiration Date
Name on Card	Total to charge

*Card Card registrations
may also be faxed
to 617 638 5051*

Please mail all correspondence to: BUGSDM Continuing Education
100 East Newton St., Suite G308
Boston, MA 02118