

REGISTRATION FORM

Name _____ Title _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____

E-Mail _____ Type of Practice _____

Dental School Graduated From _____ Year _____

Course _____ Dates _____ Fee _____

Course _____ Dates _____ Fee _____

Course _____ Dates _____ Fee _____

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 Exp. _____

Account # _____

Name on Card _____ Total: _____

*Credit card registrations may
also be faxed to 617-638-4688*

Please mail all correspondence to: **BUGSDM Continuing Education**
100 E. Newton Street, Suite G-428
Boston, MA 02118