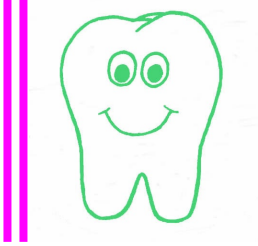

Dental Assistant Services

Infection Control Registration Form

Contact Information

Full Name

Primary Phone

◯ Home ◯ Work ◯ Cell
Please Select One

Street Address

Secondary Phone

◯ Home ◯ Work ◯ Cell
Please Select One

City/Town

State

Zip Code

Email Address

Last Four Digits of Social Security Number

Course Information

Start Date of Course
(from Website)

End Date of Course
(from Website)

Start and Ending Time
(from Website)

The full cost of this course is $_____. Please call the office at 732-919-1816 for the current rate and to assure that there is an opening in this course.

Questions

1. I would like to be called if there should be an opening for this course at an earlier date. ◯ Yes ◯ No

2. I have read and agree to all the terms and conditions as well as the copyright notice. Please note that you must mark **yes** to the right or you will not be permitted to register for this course. ◯ Yes ◯ No

Questions (cont'd)

3. Why are you planning to take this course?

◯ To Prepare for the Exam ◯ For Continuing Education Credits

◯ Exam Prep and CDE Credits ◯ Other, Please specify

Additional Instructions

After completing this registration form in its entirety, please print it out. Sign and date the form below and mail it in along with your $100 non-refundable deposit made out to Dental Assistant Services. This will reserve your seat in the course. Alternatively, you may bring this form and your deposit to our office in person.

You will be called one week prior to the start of class to confirm your registration. Prior to this, calls will only be made if your registration form is received AFTER the course has already been filled. In other words, if you do NOT receive a call from us and your bank statement shows that your $100 has been deposited you can safely assume that your registration has been accepted.

Click here for additional information about accepted forms of payment.

Signature

I certify that all information on this registration form was completed by me and is correct and accurate to the best of my knowledge.

Signature: _____ Date:

Please mail all registration materials together in one envelope to:

Dental Assistant Services
1306 Highway 33
Suite 3A
Farmingdale, NJ 07727