



## Join our e-mail list!

We'll let you know about our latest courses and special offerings for the entire dental team.

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To add your name to the list, just e-mail:

umsodce@umaryland.edu  
or call 410-706-2282.

# REGISTER TODAY BY:

## INTERNET:

[www.dental.umaryland.edu/ce](http://www.dental.umaryland.edu/ce)

## FAX:

410-706-3214

*Include registration form and credit card information*

## MAIL:

*Make checks payable to University of Maryland School of Dentistry*

University of Maryland  
School of Dentistry  
Office of Continuing Education

Suite 8102  
650 West Baltimore Street  
Baltimore, MD 21201

### **GENERAL CANCELLATION POLICY**

In case of cancellation by registrant, refunds will be made (less a \$50 admin fee) if received no later than three weeks prior to the start of course date. This does not apply to the local anesthesia course.

### **LOCAL ANESTHESIA COURSE CANCELLATION POLICY**

In case of cancellation by registrant, refunds will be made (less a \$200 admin fee) if received no later than four weeks prior to the start of course date. If cancelled within four weeks, no refunds will be issued. A credit can be issued towards the next course.

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The University of Maryland School of Dentistry reserves the right to cancel any course which does not receive sufficient enrollment. In the event that enrollment is insufficient, participants will be notified of cancellation or reschedule one week prior to course date and a full refund will be made. In such circumstances, organizers will not be held liable for any expenses already incurred by any participant.



To register, please complete the following information:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_  Please send confirmation by e-mail

Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Please check all that apply:

- DDS
- Endo
- Prosth
- UMSOD Staff
- DMD
- Perio
- Oral Surgery
- UMSOD Student
- G.P.
- Ortho
- Office Staff
- UMSOD Alum
- RDH
- Pedo
- UMSOD Faculty
- year: \_\_\_\_\_

Please register me for the following course:

Course Title \_\_\_\_\_

Course Date \_\_\_\_\_ Credit Hours \_\_\_\_\_ Tuition Total \_\_\_\_\_

Payment information:

Check or Money Order payable to: University of Maryland School of Dentistry

Please Charge My:  VISA  MASTERCARD

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

3 Digit CVV Code \_\_\_\_\_ Signature \_\_\_\_\_

Card Holder's Name (if different from registrant) \_\_\_\_\_

FOR OFFICE USE ONLY

PD: \_\_\_\_\_ CK#: \_\_\_\_\_ DD: \_\_\_\_\_

