



Continuing Education Registration Form

Please complete this form and send it to the mailing address, email or fax number seen below:

Name: _____ Degree: _____

Specialty: _____

Office Phone Number: _____ Fax Number: _____

E-mail Address: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Pre-registration is required and necessary for your convenience and comfort

Course Information:

If you have any special needs we should be aware of, please specify:

<u>Course:</u>	<u>Date:</u>	<u>Tuition:</u>
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Billing Information:

Please charge my: MasterCard Visa American Express

Account Number: Expires: /

3 Digit Security Code: Billing zip code:

Name on Card: _____

Make checks payable to UKCD CE

Mail payment with this form to:

University of Kentucky
College of Dentistry
Continuing Education
Attn. Elaine Stafford
333 Waller Avenue, Suite 100
Lexington, KY 40504

Telephone: (859) 323-8155 or 8187 **Fax:** (859) 257-1901

Email: For security reasons, please do not send any credit card information via email.