

Register Today!



University of Kentucky
College of Dentistry

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: _____

Date of Registration: _____

Course Information:

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

Please enroll me in the following course(s):

| <u>Course:</u> | <u>Date:</u> | <u>Tuition</u> |
|----------------|--------------|----------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

I wish to register as College of Dentistry faculty/staff

Division: _____

Full-time Faculty _____ Part-time Faculty _____ UKCD Staff _____ Resident _____

Billing Information:

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

Please charge my: MasterCard Visa American Express

Account Number: Expires: /

3 Digit Security Code: Billing zip code:

Card Holder Name: Cardholder Signature:

Make checks payable to UKCD CE

Mail payment with this form to:

University of Kentucky
College of Dentistry
Division of Continuing Education
333 Waller Avenue, Suite 100
Lexington, KY 40504