

REGISTRATION FORM

(PLEASE PRINT OR TYPE)

Please make additional copies for each person.

DMD ___ DDS ___ RDH ___ DA ___ OTHER _____

First Name _____ MI _____ Last Name _____

Business Address (If tuition is being paid by employer): Employer Name _____

City _____ State _____ Zip _____

Home Address (If tuition is being paid by attendee):

City _____ State _____ Zip _____

Phone (Office) _____ Phone (Cell) _____ Phone Evening _____

Email Address _____ Fax Number _____

Dental School Attended: _____ Graduation Date _____

SDM Faculty: Full-Time ___ Part-Time ___ Emeritus ___ Volunteer ___

Course Information

Course Number _____ Course Fee _____ Course Number _____ Course Fee _____

Course Number _____ Course Fee _____ Course Number _____ Course Fee _____

Course Number _____ Course Fee _____ Course Number _____ Course Fee _____

Payment Information

Check Amount \$ _____ (Payable to the University of Pittsburgh)

Visa _____ MasterCard _____ Discover _____

Card # _____ Expiration Date _____

Full Name (As it appears on card) _____ (Print or Type)

Signature _____

Please return completed form to:
**The University of Pittsburgh, School of Dental Medicine, 2148 Salk Hall,
Edward J. Forrest CDE Center, Pittsburgh, PA 15261.
Phone: 412/648-8370 Fax: 412/383-9069**

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