Mid-Atlantic Center for Advanced Dental Study

Registration Form

Name _____ DDS/DMD/CDT CDT# _____

Address _____ AGD# _____

City _____ State _____ Zip _____

Phone (office) _____ (fax) _____ (cell-optional) _____

E-mail _____

Course registering for _____

Course date _____ Course tuition _____

What is the best time to reach you to confirm your registration? _____

How did you hear about this course? _____

Do you have any dietary restrictions or allergies? _____

Form of Payment

❏ Full tuition ❏ $100 per person deposit to reserve seat (transferable/non-refundable)
balance due 30 days prior to course date

❏ Check or Money Order enclosed ❏ Visa ❏ MasterCard ❏ American Express

Card # _____ Exp. Date _____ V-Code _____

Cardholder Name _____ Signature _____

Billing Address (if different from above) _____

City _____ State _____ Zip _____

Please mail this form to 1207 Volvo Parkway, Chesapeake, Virginia 23320
or email Grace Bogan at grace@bvdl.com

Thank you for registering! We will be contact you soon with confirmation.

Cancellation Policy
Full refund less $100 processing fee if cancelled 30 days before the course. Cancellation received within 30 days of scheduled class is accommodated with a one-time transfer to a future class - no refunds.

1207 Volvo Parkway
Chesapeake, VA 23320-7654
757-222-9843
www.mid-atlanticcenter.com