

TO ENROLL: Please fill in this Registration Form completely and send in with your payment (enrollment is not complete without payment) to:

Bronx-Lebanon Hospital Center
Department of Dentistry
Dr. Paul E. Gates
Suite 2F
1770 Grand Concourse
Bronx, NY 10457

TO ENROLL BY PHONE: Please call (718) 901-8110 or (718) 901-8410

TO ENROLL BY FAX: Please FAX your completed registration form to (718) 901-8121

Course Title: Simulated Implant Placement/Restoration

Course Date: October 22, 2009 through October 25, 2009

Course Credit: 23 CME

Course Fee: \$2,000

(Registration fee of \$595 due with registration by September 22, 2009 with balance due by October 15, 2009)

Name: _____

Office Address: _____

Suite #: _____

City/State/Zip: _____

Office Phone: _____

Home Phone: _____

FAX No.: _____

E-mail address: _____

Dental School: _____

Year of Graduation: _____

Specialty/Position: _____

Date of Birth: _____

Enclosed (Payable to Dr. Paul E. Gates): () Check () Mastercard () Visa

Cardholder's Name: _____

Card Number: _____ and 3-digit security code: _____

Expiration Date: ____/____/____