



Registration Form for Orthodontic Expanded Duties Course

Name: \_\_\_\_\_

Name as to appear on certificate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ email address: \_\_\_\_\_

Doctor's name: \_\_\_\_\_ Doctor's phone: \_\_\_\_\_

Address to send certificate to: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Exam date \_\_\_\_\_

Please forward the following items:

\_\_\_\_\_ Check for \$100.00 ( Made payable to: G.A.O.)

Mail to Brenda Oliver  
Office of J. Don Spillers, Jr., DMD  
400 Spillers Way  
Warner Robins, GA 31088

\_\_\_\_\_ Letter verifying at least 6 months employment as an orthodontic clinical assistant.

-Registration and documents can be emailed to [brenda@drspillers.com](mailto:brenda@drspillers.com)

-Registration closes 7 days prior to class date.