

Registration Form for Orthodontic Expanded Duties Course

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

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

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

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

Phone: \_\_\_\_\_

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

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

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

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

Please enclose the following items:

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

\_\_\_\_\_ Letter verifying at least 6 months employment