

Achieve Endodontic Excellence: *Shaping, Cleaning, & Disinfecting*



Charles Goodis, DDS

When:

Friday, October 29, 2010

Where:

Holiday Inn-Carrier Circle
6555 Old Collamer Rd
E. Syracuse, NY

Time:

8:00 - 8:30 Registration
8:30 - 9:00 Meeting
9:00 - 4:00 Seminar

Fax Your Registration to:
315-437-6013

Mail Your Registration to:
Fifth District Dental Society
6323 Fly Road, Ste. 3
E. Syracuse, NY 13057

Pre-Registration Form

DEADLINE FOR PRE-REGISTRATION IS OCT 26, 2010

Dental Practice / Primary Dentist Name: _____
Tel Number: _____ Fax Number: _____ Email: _____

Mailing Address (Confirmations of all registrants listed below will be sent to this address or faxed/mailed to above info.)
Street _____
City _____ State _____ Zip _____

Course Credit: 7 MCE

\$210 MEMBER*, \$420 NONMEMBER*, \$135 STAFF/RESIDENTS*

**Continental Breakfast, Lunch and
Afternoon Break is Included**

REGISTRANT 1 Full Name: _____
 Dr. Ms. Mr. _____
ADA #(Dentists/Students) / SS# (Others) _____
 DDS/DMD RDH DA Course Fee: \$ _____

REGISTRANT 2 Full Name: _____
 Dr. Ms. Mr. _____
ADA #(Dentists/Students) / SS# (Others) _____
 DDS/DMD RDH DA Course Fee: \$ _____

REGISTRANT 3 Full Name: _____
 Dr. Ms. Mr. _____
ADA #(Dentists/Students) / SS# (Others) _____
 DDS/DMD RDH DA Course Fee: \$ _____

REGISTRANT 4 Full Name: _____
 Dr. Ms. Mr. _____
ADA #(Dentists/Students) / SS# (Others) _____
 DDS/DMD RDH DA Course Fee: \$ _____

REGISTRANT 5 Full Name: _____
 Dr. Ms. Mr. _____
ADA #(Dentists/Students) / SS# (Others) _____
 DDS/DMD RDH DA Course Fee: \$ _____

PAYMENT METHOD:

Please bill my: MC Visa Discover Amex

Credit Card Number: _____

Exp. Date: _____ Signature: _____

Check enclosed *Payable to:* Fifth District Dental Society

Total Fee For All Registrants: \$ _____