General CE Registration Form

Contact Information—Please complete all fields.

- First Name: _______________________________ MI: ________________________
- Last Name: ___________________________________________________________
- Business Affiliation: ____________________________________________________
- Degree: ______________________________________________________________
- Office Address: ________________________________________________________
- City: _________________________________________________________________
- State: _______________________________ Zip: ____________________________
- Office Phone: __________________________________________________________
- Fax Number: ___________________________________________________________
- Email Address: _________________________________________________________

Course Information

- Name of Course: _________________________________________________________
- Location of Course (if offered at multiple locations): __________________________
- Dates/Times (if a date and time selection is necessary): ________________________

Payment Information—Please complete all fields.

- Payment Method:  _____ VISA   _____ MasterCard  _____ Check payable to UKCD CE
  - Name on Card: _________________________________________________________
  - Expiration Date: ______________________________________________________
  - Signature: ____________________________________________________________
  - Billing Address for Card: ______________________________________________
    (Street, City, State, Zip)

Form Submission Information

- Fax completed form to: (859) 257–1901
- Mail payment and completed form to: University of Kentucky, College of Dentistry Continuing Education, 800 Rose Street, Attn. Elaine Stafford, Dental Science Bldg., Lexington, KY 40536-0297
- Call (859) 323–8155 or (859) 323–8187 to register