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

• To pay by check, make payable to UKCD CE

• To pay by credit card, please register online or call (859) 323-8187.

Form Submission Information

• Fax completed form to: (859) 257–0486 - payment required by mail or by phone
• Mail payment and completed form to: University of Kentucky, College of Dentistry Continuing Education, 800 Rose Street, Dental Science Bldg., Lexington, KY 40536-0297
• Call (859) 323–8187 to register