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, MN-316 Dental Science Bldg., Lexington, KY 40536-0297
- Call (859) 323–8155 or (859) 323–8187 to register