CONTINUING EDUCATION COURSE ENROLLMENT
UMKC SCHOOL OF DENTISTRY

TO ENROLL, PLEASE FILL OUT THIS FORM AND SEND VIA:

<table>
<thead>
<tr>
<th>MAIL</th>
<th>EMAIL</th>
<th>FAX</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UMKC School of Dentistry Continuing Education Department 650 E. 25th Street, Room 411 Kansas City, MO 64108</td>
<td>Send to: <a href="mailto:umkcdentalce@umkc.edu">umkcdentalce@umkc.edu</a></td>
<td>Send to: (816) 235-5892</td>
<td>Call: (816) 235-2142</td>
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COURSE INFORMATION
If attending more than one course, please send in separate sheets for each course.

COURSE TITLE: ______________________________________
COURSE NUMBER: ___________________________ TUITION: $ ________________

ATTENDEE INFORMATION
If attending in a group, please send separate sheets for each individual. All information cited below will be used to communicate course details and for your CE verification letter verifying your participation in the course.

TITLE: ☐ DR. ☐ MRS. ☐ MR. ☐ MS. ☐ OTHER __________
NAME: _______________________________________
ADDRESS: ______________________________________
PHONE: ______________________ FAX: ______________________
EMAIL: _______________________________________

AGD NUMBER: ___________________________
LICENSE NUMBER: _______________________
CREDENTIALS: ☐ DDS ☐ DMD ☐ RDH ☐ DA ☐ OTHER ________

PAYMENT INFORMATION:
If paying for multiple people, please indicate on form who else is covered by the payment below.

CHECK (Made payable to: UMKC School of Dentistry Continuing Education)
ENCLOSED CHECK NUMBER: __________________________
or

CARD
CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER
NAME ON CARD: ______________________________________
CARD NUMBER: ______________________________________
EXPIRATION DATE: __________________________
BILLING ZIP CODE: __________________________