

COURSE REGISTRATION FORM

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Please complete this form and email to info@ptifa.com or fax to 604-670-1166.

DOCTOR INFORMATION

First Name:	Last Name:
Cell Phone:	Email:

PRACTICE INFORMATION

Address:		
City:	State:	Zip:
Phone:	Fax:	

HOW DID YOU HEAR ABOUT US?

- | | | |
|--|---------------------------------------|---|
| ☐ Convention | ☐ Mail-out | ☐ Colleague: _____ |
| ☐ Oral Health | ☐ Google | |
| ☐ Dentistry Today | ☐ Social Media | ☐ Other: _____ |

DOCTOR REGISTRATION

	DATE	CITY	FEE
☐ L1A	ONLINE COURSE		CDN: \$1,345 US: \$1,695
☐ L1B			\$1,200
☐ L2			\$3,400
☐ L3			\$3,400
☐ L4			\$3,400
☐ L5			\$3,400
Subtotal A:			\$

TEAM MEMBER REGISTRATION

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	First Name	Last Name	L1A	L1B	L2	L3	L4	L5	Total
1			☐ \$199	☐ \$199	☐ \$799	☐ \$799	☐ \$799	☐ \$799	\$
2			☐ \$199	☐ \$199	☐ \$799	☐ \$799	☐ \$799	☐ \$799	\$
3			☐ \$199	☐ \$199	☐ \$799	☐ \$799	☐ \$799	☐ \$799	\$
4			☐ \$199	☐ \$199	☐ \$799	☐ \$799	☐ \$799	☐ \$799	\$
5			☐ \$199	☐ \$199	☐ \$799	☐ \$799	☐ \$799	☐ \$799	\$
6			☐ \$199	☐ \$199	☐ \$799	☐ \$799	☐ \$799	☐ \$799	\$
Subtotal B:									\$

REGISTRATION SUMMARY

Doctor Registration (A): \$ _____

Team Member Registration (B): \$ _____

Subtotal: \$ _____

Tax (5%): \$ _____

Grand Total: \$ _____

PAYMENT INFORMATION

Name on card: _____

Credit card #: _____

Expiry: _____ 3 digit code: _____

Signature: _____

PATIENT INFORMATION

In order to process your registration form, please initial each point.

- _____ I understand that I am responsible for providing at least one patient for any hands-on clinical session.
- _____ I am responsible for contacting the clinic to reserve an appointment time for my patient (Vancouver clinic: 604-688-4422, Calgary clinic: TBA).
- _____ I understand that there is a cost of \$6/unit (courtesy rate) for my patient to have Botox® treatment.