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