Dental Ed

CDAAC REGISTRATION FORM V2018

MAKE SURE THAT YOUR 'HANDWRITTEN' FORM IS LEGIBLE OR YOUR REGISTRATION WILL NOT BE PROCESSED

Student Name: _____

Course Date: _____

College registration number if applicable: _____

Title: Dental Hygienist: ☐ CDA/RDA: ☐ Other: ☐

New enrollment: ☐ Recertification: ☐

Student email address: _____
(for online quizzes)

Student cellphone number: _____
(for contacting on course day if needed)

Dentist who paid the tuition if not paid by you: _____

Practice you are associated with: _____

Practice owner email address: _____

Does your practice treat primarily pediatric patients: Yes: ☐ No: ☐

I have faxed or emailed a copy of my current valid **Health Care Provider** CPR certificate

Yes: ☐ No, will fax soon: ☐ No will show proof at course: ☐

Paid for as course add-on: ☐

Fax to: 1-604-800-0487 or email to info@dental-ed.com