# ATLANTIC COAST DENTAL RESEARCH CLINIC
# COURSE REGISTRATION 2019 - 2020

**Please mark your course selection:**

| **SECTION** | **CHAIRMAN** |
|---|---|
| ___Clinical Excellence in Comprehensive Dentistry | Dr. Jiveh |
| ___Craniofacial Pain and TMJ Disorder | Dr. Abdel-Fattah |
| ___Combined Course of Everyday Dentistry and Medications in a Nutshell | Dr. Klein |
| ___Contemporary Endodontics | Dr. Allan Moskow |
| ___Implants: Placement and Restoration | Dr. Blake |
| ___Oral Implantology | Dr. Miller |
| ___Oral Surgery in the Dental Practice | Dr. Rouleau |
| ___Contemporary Orthodontics | Dr. Shults |
| ___Periodontal Esthetics & Regeneration | Dr. Feldman |
| ___Successful Removable Prosthetics | Dr. Fisher |

**Please Type or Print:**

NAME:_____

ADDRESS:_____

CITY/ZIP:_____

TELEPHONE:_____

EMAIL ADDRESS:_____FAX:_____

LICENSE#:_____AGD#_____

**___* I am a 2018 Dental Graduate**

I,_____being a duly licensed Florida dentist do hereby apply for membership in the Atlantic Coast Dental Research Clinic. I certify that I am presently carrying liability insurance in the minimum amount of $250,000/750.000. I understand it is my responsibility to attend both the didactic and clinical sessions of my chosen course.

SIGNATURE:_____DATE:_____