

**ATLANTIC COAST DENTAL RESEARCH CLINIC
COURSE REGISTRATION 2020 - 2021**

Please mark your course selection:

SECTION

CHAIRMAN

<input type="checkbox"/> Craniofacial Pain and TMJ Disorder VIRTUAL	Dr. Abdel-Fattah
<input type="checkbox"/> Implants: Placement and Restoration	Dr. Blake
<input type="checkbox"/> Oral Implantology	Dr. Miller
<input type="checkbox"/> Modern Dental Office Technologies	Dr. Sauchelli
<input type="checkbox"/> Oral Surgery in the Dental Practice	Dr. Rouleau
<input type="checkbox"/> Contemporary Orthodontics VIRTUAL	Dr. Shults
<input type="checkbox"/> Periodontal Esthetics & Regeneration	Dr. Feldman
<input type="checkbox"/> Soft Tissue Considerations in Esthetic, Restorative And Implant Therapy VIRTUAL	Dr. Gutierrez
<input type="checkbox"/> Successful Removable Prosthetics	Dr. Fisher

Please Type or Print:

NAME: _____

ADDRESS: _____

CITY/ZIP: _____

TELEPHONE: _____

EMAIL ADDRESS: _____ FAX: _____

LICENSE#: _____ AGD# _____

*** I am a 2020 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: _____