**ATLANTIC COAST DENTAL RESEARCH CLINIC**

**COURSE REGISTRATION 2021 - 2022**

**Please mark your course selection:**

**SECTION CHAIRMAN**

\_\_\_Craniofacial Pain and TMJ Disorder (Virtual) Dr. Abdel-Fattah

\_\_\_Implants: Placement and Restoration Dr. Blake

\_\_\_Oral Implantology Dr. Miller

\_\_\_Modern Dental Office Technologies Dr. Sauchelli

\_\_\_Oral Surgery in the Dental Practice Dr. Rouleau

\_\_\_Periodontal Esthetics & Regeneration Dr. Feldman

\_\_\_Digital Dentures Dr. Dixon

**Please Type or Print:**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LICENSE#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGD#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\* I am a 2021 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_