

**ATLANTIC COAST DENTAL RESEARCH CLINIC
COURSE REGISTRATION 2024 - 2025**

Please mark your course selection:

SECTION

CHAIRMAN

<input type="checkbox"/> Digital Dentistry: 3D Printing for Restorations	Dr. Dixon
<input type="checkbox"/> Implants: Placement and Restoration	Dr. Blake
<input type="checkbox"/> Oral Implantology	Dr. Miller
<input type="checkbox"/> Periodontal Esthetics & Regeneration	Dr. Feldman
<input type="checkbox"/> Predictable Digital Dentures: A CAD/CAM Approach	Dr. Dixon

Please Type or Print:

NAME: _____

ADDRESS: _____

CITY/ZIP: _____

TELEPHONE: _____

EMAIL ADDRESS: _____ FAX: _____

LICENSE#: _____ AGD# _____

*** I am a 2024 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: _____