ATLANTIC COAST DENTAL RESEARCH CLINIC
COURSE REGISTRATION 2026 - 2027

Please mark your course selection:

SECTION	CHAIRMAN
___Elevated Aesthetic Dentistry	Dr. Jiveh
___Endodontics	Dr. Reyes
___Implants: Placement and Restoration	Dr. Blake
___Oral Implantology	Dr. Knecht
___Periodontal Esthetics & Regeneration	Dr. Feldman
___Practical Excellence in Restorative Dentistry	Dr. Barr
___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 2026 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:_____