Registration Continuing Education Courses

Columbia University College of Dental Medicine

Name(s) _____

Address _____

Phone _____ **Fax** _____ **Email** _____

CDM Class Year / Specialty Program _____

Please register me for the following course(s):

1. Date _____ Title _____ Fee $ _____
2. Date _____ Title _____ Fee $ _____
3. Date _____ Title _____ Fee $ _____

Payment ❑ Check ❑ Visa ❑ Mastercard ❑ AmEx

Card # _____ Expiration _____

Name on Card _____

Billing Address (if different from above) _____

$ _____ Total Enclosed

Reminder: CDM alumni & dental hygienists receive 10% off listed tuition, CDM faculty deduct 50%, and alumni graduating within 5 years deduct 20%.

Please visit http://dental.columbia.edu/ce/ for complete course listings. To register, complete and fax this form to (212) 342-5179 or mail with payment to:

Continuing Education
Columbia University College of Dental Medicine
630 West 168th Street, Box 20
New York, NY 10032