CDIMPLANT ACADEMY

CDI Cleveland Dental Institute

Registration Form.

Please photocopy this form

Name: ________________________ **Degree:** ________________________

Address:____

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City:__________________________ **State:**____________________ **Zip:**__________

Email:__________________________ ☐ Please send confirmation by email.

Office phone: ________________________ **Cell phone:** ____________________

Fax: ________________________________ **Home Phone:**____________________

Please Check:

☐ General Dentist ☐ Specialist *(Please specify):* _______________ Yr. of graduation______

Payment information:

☐ **Check or money order payable to:** Cleveland Dental Institute

Please charge my: ☐ Master Card ☐ Visa Card ☐ Discover ☐ American Express

Card#: ________________________________ **Exp. Date:** ________________

Billing address *(If different than above)*: ________________________________

City: __________________________ **State:** ____________________ **Zip:** __________

Card holder's name *(If different than registrant)*: ____________________________

Signature: ____

Ways to register:

Online: cdiacademy.org **By phone:** (440)520-0603 **By fax:** (216)721-8171

By mail: *Complete & send registration form to:* Cleveland Dental Institute. 11201 Shaker Blvd. Suite 136. Cleveland OH. 44136.

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Dates/Time: September 21st 2017. 8:00am to 5:00pm each day

Course tuition: $19,000:Register by August 24th - $22,000: Register after August 24th

A deposit of $7,000 is required upon registration

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For more information please contact us by:

Phone: (440)520-0603 Email: l.amoud@cdiohio.org