23rd Annual Handelman Conference Registration Form

To register online visit: Handelman.urmc.edu

Name____

Address____

City/State/Zip _______________________________________

Business Phone (______) ______________________________

Fax (______) ____

Email ____

School and Year _____________________________________

Specialty ____

ADA # (if applicable) _________________________________

PAYMENT

☐ Check enclosed (payable to Eastman Institute for Oral Health)

☐ Credit Card ☐ Visa ☐ MasterCard

Card # ____

Expiration Date ______________________________________

Check one: ☐ Dentist ☐ Technician ☐ Auxiliary ☐ Resident

Total Amount $_______________________________________

Signature (required) __________________________________

RETURN BY MAIL

Eastman Institute for Oral Health
Box 683
625 Elmwood Avenue
Rochester, NY 14620-2989
Attn.: Lisa Crosier

RETURN BY FAX

(585) 273-1235

Please mail or fax your registration by April 22nd.

Cancellation: Tuition will be refunded until April 29th, minus a $25 cancellation charge.

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