

# Academy of Orthodontic Assisting

## Application

### Clinical Efficiency Retreat

Please fax to 678.370.9848 or mail to 2161 Cedarcrest Rd., #115 Acworth, GA 30101

Participants Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Education:

High School: \_\_\_\_\_

College: \_\_\_\_\_

Other: \_\_\_\_\_

Dental/Ortho experience (please specify any licensing, certifications, and time in the field):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why are you attending the CERetreat? \_\_\_\_\_

\_\_\_\_\_

If you currently work for an orthodontist, what are your duties in the office? \_\_\_\_\_

\_\_\_\_\_

Are you allergic to latex? \_\_\_\_\_

When & Where?

Location: \_\_\_\_\_ Level I  Level II

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Tuition Arrangements:

#\_\_ Level I \$400 per participant

#\_\_ Level II \$500 per participant

**Total: \$** \_\_\_\_\_

MC \_\_\_\_\_ Visa \_\_\_\_\_ Discover \_\_\_\_\_ Check # \_\_\_\_\_

Card# \_\_\_\_\_ Exp: \_\_\_\_\_

CVM# \_\_\_\_\_ \*3 digit security code on back of card

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Name on card \_\_\_\_\_

Signature of card holder \_\_\_\_\_