DENTAL DEVELOPMENT SEMINARS

1515 MAIN STREET CONWAY SC 29526

PHONE (843) 488-4357

Email Completed Form to [drtommymurph@yahoo.com](mailto:drtommymurph@yahoo.com)

Course Date: \_\_\_\_\_\_\_\_\_\_\_\_ Course Fee: $7000

NAME THE CREDIT CARD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CREDIT CARD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_\_\_\_\_\_ SECURITY CODE ON CARD:\_\_\_\_\_\_\_

Street Address of Statement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City of Statement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State or Province:\_\_\_\_\_\_\_\_\_\_\_\_\_

POSTAL CODE OF STATEMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE PHONE OF CC HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE OF CC HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGD# \_\_\_\_\_\_\_\_ ARE YOU A VEGETARIAN \_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

T-SHIRTS SIZE \_\_\_\_\_\_\_\_\_\_

HOTEL ROOM SINGLE OR DOUBLE WITH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL LICENSE STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME ON CE VOUCHER: \_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation/Refund Policy:**

Refund Policy 50% 90 days prior, 25% 60 days prior to class start. No refunds under 60 days.  If cancellation occurs within 5 business days of sign up there is a $100 processing fee.  All cancellation requests will be processed within 30 days after course completion. $50.00 fee for returned checks.

I attest that the above information is correct and that I have read and agree to the cancellation/refund policy above

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_