Infection Control for the Dental Technologist
April 21, 22nd , 2018

Name: First _____ Last _____

Dental Technologist Membership # _____ Province of Registration: _____

ADDRESS: _____

CITY:_____PROVINCE:_____POSTAL CODE: _____

PHONE: ( )_____FAX: ( ) _____

EMAIL (required):_____

☐ I have submitted a copy of my current practice permit

☐ Payment of $665 submitted on (Day/Month/Year) _____

Please Circle VISA M/C

Card # _____ Exp_____

3 digit Code (back of card)_____

CDI College reserves the right to limit enrollment, cancel, or change the location, time, course content, or teaching personnel of any course as may be deemed necessary or advisable

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