

**REGISTRATION FORM**

**Practical Excellence in Restorative Dentistry 2009-2010** (128453A)

Please Check & please use one form per person-photocopy as needed.

**TUITION**

**Dentist: \$4837.50** Save \$837.50 off the tuition fee by making a one-time payment of \$4,000 (which includes a non-refundable \$500 deposit) by August 3, 2009.

**Dentist:** We received a non-refundable deposit of \$500 before July 13, 2009 and you now qualify for \$437.50 off the full tuition fee.

**Dentist:** We received a non-refundable deposit of \$500 between July 13 and August 3, 2009 and you now qualify for \$237.50 off the full tuition fee.

**Now you qualify for either a \$437.50 or \$237.50 discount (based on the receipt of non-refundable deposit)**

Pick one of the plans below and you will qualify for an additional savings. ex: If you choose plan #1 you will receive an additional discount of \$300 for a total of \$737.50 (\$300 + \$437.50) or \$537.50 (\$300 + \$237.50)

**Please choose which payment plan you wish to participate in:**

**PLAN #1:** If you pay the entire balance due (based on your deposit date) before August 14, 2009 you will receive an additional \$300.00 off the remaining balance.

**PLAN #2:** Pay the entire balance due (based on your deposit date) before September 1, 2009 and you will receive an additional \$200.00 off the remaining balance.

**PLAN #3:** Start making the first of 5 successive monthly payment plans (based on your balance due) before August 14, 2009 and you will receive an additional \$100.00 off the remaining balance.

**PLAN #4:** If you make the first of 5 successive monthly payment plans (based on your balance due) before September 3, 2009 and you will receive an additional \$50.00 off the remaining balance.

*No fee reductions are available after September 3, 2009 but a five successive monthly payment plan is available.*

Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  DDS  DMD  
Date of Birth

Office Address \_\_\_\_\_ Suite No. \_\_\_\_\_

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

Home Address \_\_\_\_\_

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

Office No. \_\_\_\_\_ Home No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Email \_\_\_\_\_

Dental School \_\_\_\_\_ Year of Graduation \_\_\_\_\_

Specialty/Position \_\_\_\_\_

Enclosed (payable to UTHSCSA): Check No. \_\_\_\_\_

Visa  MasterCard  Discover

Card No. \_\_\_\_\_

(include the last three numbers on the signature part of the card) \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name on Card \_\_\_\_\_