

- I am a Dentist ____, Laboratory Technician ____, Dental Assistant ____, Dental Hygienist ____
Enclosed is my check for \$488.00 (\$548.00 after **August 15, 2018**) for a **NON-TRANSFERABLE MEMBERSHIP** in the Colorado Prosthodontic Society which includes 6 meetings and 6 lunches.
- Enclosed is my check for **\$175 for one seminar only.** Speaker: _____
Date: _____. If registering less than 7 days prior to meeting, \$225.00
- I am a Dentist and will bring with me _____ (#) non-dentist team members to a meeting. \$99/person. If registering less than 7 days prior to a meeting, the cost is \$125/person.

Date: _____. Team member names: _____ / _____ / _____

NAME _____ **PHONE (** _____ **)** _____

ADDRESS _____

CITY, STATE, ZIP _____ ***Required: Email** _____

YEAR OF DENTAL SCHOOL GRADUATION _____

Colorado Prosthodontic Society is now a non-profit organization accepting donations for charitable dental programs.
If you are interested in donating, please speak to a CPS officer.

Check if address is new or has changed since last year.

*Tear off at perforation and mail with membership fee. *For seminar handouts and announcements.*

Make checks payable to:
Colorado Prosthodontic Society
and mail with this registration form to:

Colorado Prosthodontic Society
PO Box 462283
Aurora, CO 80046-2283

OR
Register on the Internet at
www.coloradoprosthodonticsociety.org

If registering and paying by credit card
please fill in the information below:

Visa MasterCard

Signature _____

Card# _____

Exp. _____ Date _____

REGISTRATION