

# REGISTRATION FORM

Please type or print clearly on both sides of this registration form.

**\*\* One registrant per form -- copy as necessary \*\***

Name: \_\_\_\_\_  
(Last) (First)

Circle appropriate title: HYGIENIST DENTIST EFDA ASSISTANT  
 OFFICE MANAGER RECEPTIONIST STUDENT OTHER:

ADHA Member ID Number: \_\_\_\_\_  
(this will be confirmed)

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

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

Home Phone: ( ) \_\_\_\_\_ Office Phone: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Local Component (ADHA Members): \_\_\_\_\_

School (Students): \_\_\_\_\_

- Please check here if you DO NOT wish to receive sponsor mailings
- Please check here if you DO NOT wish to have your photo appear in any publication



## VOLUNTEERS NEEDED

We need your help. Will you be a course **host** or **ticket taker**? If you are willing to do this, please fill-in below. You will be contacted before the event.

Yes, I will be a:

Host

Ticket taker



Please contact me with more instructions.

## REGISTRATION FEE

*(must be included)*

**Registration Deadline April 2, 2010**

Check your membership status:	Postmarked by April 2nd	Postmarked after April 2nd & all on-site
___ ADHA Member	\$20.00	\$35.00
___ Dental Hygiene Student	\$20.00	\$35.00
___ Non-member Dental Hygienists	\$35.00	\$50.00
___ Other health professionals	\$35.00	\$50.00

On-site registration **May Not** include lunch option due to banquet confirmation requirements.

Registration Fee \$ \_\_\_\_\_  
(circle this registration fee on the reverse side)

Refund requests must be postmarked by April 14, 2010 and **Will Not** be accepted after that date.

# Course Registration

Circle desired course(s) & enter appropriate fee on the line provided.

Your Name: \_\_\_\_\_

## Course Fees

ADHA Non ADHA  
Members Members

### Thursday - April 22, 2010

Oral Cancer-Facts and Tools for Your Practice(Osuna)(3 CEUs) .....	\$55.00	\$70.00	_____
Sharpen Up- It's a Smart Thing to Do!(Bendit)(3 CEUs) .....	\$55.00	\$70.00	_____

### Friday - April 23, 2010

#### Morning Programs

What is It? How Do I Use It?(Osuna)(3 CEUs) .....	\$55.00	\$70.00	_____
Enamel Therapy: the Next Generation of Care(Bendit)(3 CEUs) .....	\$55.00	\$70.00	_____
Sitting Pretty- Reducing Ergonomic Challenges in Our Tx Rms(Guignon)(3 CEUs)	\$55.00	\$70.00	_____

<b>Friday Lunch</b> 12:00-1:00 {write FREE if you want lunch and are taking TWO Friday courses;} {the cost for lunch is \$15.00 if only taking ONE Friday course}	<b>Free or \$15</b>	
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#### Afternoon Programs

Breakthrough Biofilm Concepts (Guignon)(3 CEUs) .....	\$55.00	\$70.00	_____
Would Your Office Pass an OSHA Inspection?(Roman)(3 CEUs) .....	\$55.00	\$70.00	_____
Forensics: Taking a Bite out of the Practice of Dentistry(Wright)(3 CEUs) ...	\$55.00	\$70.00	_____

<b>Exhibitors' Extravaganza ~ 4:00-6:00</b> (check here if you will attend) <input type="checkbox"/>
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### Saturday - April 24, 2010

#### Morning Programs

Melting Tooth Syndrome.....(Guignon)(3 CEUs) .....	\$55.00	\$70.00	_____
Achieve Health in 5 mm Pockets w/ Scoops Not Scalers(O'Hehir)(3 CEUs).	\$55.00	\$70.00	_____
The Mysterious Mole(Nanne)(3 CEUs) .....	\$55.00	\$70.00	_____

<b>Saturday Lunch</b> 12:00-1:00 {write FREE if you want lunch and are taking TWO Saturday courses;} {the cost for lunch is \$15.00 if only taking ONE Saturday course}	<b>Free or \$15</b>	
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#### Afternoon Programs

Oh Baby! The Essential ABC's of Infant & Toddler Oral Care(Blackiston)(3 CEUs)	\$55.00	\$70.00	_____
Bleeding, Bugs & Bad Breath(O'Hehir) (3 CEUs) .....	\$55.00	\$70.00	_____
CPR Recertification(McClure)(3 CEUs).....	\$55.00	\$70.00	_____

### Registration Fee (See other side)

If postmarked by April 2nd .....	\$20.00	\$35.00	_____
If postmarked after April 2nd.....	\$35.00	\$50.00	_____

Please make checks payable to: **ODHA** and mail or fax along with the completed registration form to:

ODHA Total Development Weekend  
Katie Camp, RDH  
ODHA Administrative Assistant  
4045 Langston Place, Apt. K  
Sylvania, OH 43560  
Fax Number: 419-866-4311

Registrations must be postmarked by:  
**April 2, 2010**

### Method of Payment:

\_\_\_ Check enclosed \_\_\_ Visa \_\_\_ MasterCard

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

PRINT YOUR NAME AS IT APPEARS ON YOUR CREDIT CARD:

\_\_\_\_\_

Signature: \_\_\_\_\_

For office use only

Check #	Amount	Description
		___ Personal
		___ Dr. _____

**Please complete both sides of form**