

West Coast District Dental Association
Continuing Education Voucher Request

Name of Course: _____

Speaker(s): _____

Date(s) of Course: _____ **Site:** _____

Course Start Time: _____ **Course End Time:** _____

Registration Fee(s): _____

Deadline for Preregistration: _____

Continuing Education Credits (Requested): _____

Course Sponsors:

Your Association Name: _____

Co-Sponsor, if applicable: _____

Sponsor Contact Person (forms will be mailed to this individual)

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

NUMBER OF VOUCHERS REQUESTED: _____ **

Return this form to:
West Coast District Dental Association
1114 Kyle Wood Lane
Brandon, Florida 33511
(813) 654-2500 or FAX (813) 654-2505

For office use only:

Date Rcvd: _____ CE Broker: _____ Calendar: _____ Mailed: _____