

REGISTRATION FORM

Please complete this form to register. To register by mail or fax, please submit this form to:
Boston University Institute for Dental Research and Education Dubai

P.O. Box: 505097

Dubai Healthcare City

Dubai, UAE

Fax number: +9714 424 8686

Tel: +9714 424 8612

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First name

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Last name

Note: The name mentioned above will be used on the certificate of attendance. Please ensure correct spelling.

Please indicate your profession:

- General Dentist Prosthodontist Pediatric Dentist Endodontist
 Periodontist Dental Student Dental Assistant Other.....

Address:.....

P.O. Box:.....

Country: City:.....

Postal Code (if applicable): Tel :

Fax: Email:.....

Registration fee AED 600

The fee will include daily lunch, coffee breaks, and certificate of attendance.

Payment:

Check: Please send check to Boston University Institute for Dental Research and Education -
Dubai, P.O. Box: 505097, Dubai Healthcare City, Dubai, UAE

Credit Card Details:

Visa MasterCard

Credit Card Number

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Verification Code

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Note: Card holder shall honor this transaction and the amount charged for registration will be non refundable.

Expiration date:.....

Name on card:

Signature:.....

For additional information, please contact:

Boston University Institute Dental Research & Education

Tel: 04-4248612

Fax: 04- 4248686

Email: sharon.revera@budubai.ae