ACP 19 49TH ANNUAL SESSION
OCT 30-NOV 2 • MIAMI

Oct. 30 – Nov. 2, 2019

Sponsored Dentist Registration Form

PART 1 ACP MEMBER INFORMATION

PLEASE TYPE OR PRINT CLEARLY

First Name | Middle Initial | Last Name

Company Name

Email (Required)

PART 2 SPONSORED DENTIST INFORMATION

SPONSORED DENTIST #1

I am sponsoring the following non-prosthodontist dentist:

First Name | Middle Initial | Last Name

Company Name

Address Line 1

Address Line 2

Address Line 3

City | State/Province | ZIP/Postal Code | Country

Business Phone | Cell Phone

Email (Required - Confirmations will be sent via email)

Emergency Contact | Daytime Phone | Evening Phone

☐ Special Needs – If you have a disability as defined by the American Disabilities Act that requires special needs, accommodations, or requirements, please check this box and you will be contacted by a staff person.

SPONSORED DENTIST #2

I am sponsoring the following non-prosthodontist dentist:

First Name | Middle Initial | Last Name

Company Name

Address Line 1

Address Line 2

Address Line 3

City | State/Province | ZIP/Postal Code | Country

Business Phone | Cell Phone

Email (Required - Confirmations will be sent via email)

Emergency Contact | Daytime Phone | Evening Phone

☐ Special Needs – If you have a disability as defined by the American Disabilities Act that requires special needs, accommodations, or requirements, please check this box and you will be contacted by a staff person.

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Sponsored Dentist Registration Form (cont.)

PART 2 SPONSORED DENTIST INFORMATION (cont.)

SPONSORED DENTIST #3

I am sponsoring the following non-prosthodontist dentist:

First Name | Middle Initial | Last Name

Company Name

Address Line 1

Address Line 2

Address Line 3

City | State/Province | ZIP/Postal Code | Country

Business Phone | Cell Phone

Email (Required - Confirmations will be sent via email)

Emergency Contact | Daytime Phone | Evening Phone

☐ Special Needs – If you have a disability as defined by the American Disabilities Act that requires special needs, accommodations, or requirements, please check this box and you will be contacted by a staff person.

PART 3 PAYMENT

	FEE	QTY.	TOTAL
TOTAL SPONSORED DENTIST(S)	$700	_____	$ _____

☐ **Check**

Checks must be made payable to the American College of Prosthodontists and issued in U.S. funds, or registrations will not be processed. Checks returned for insufficient funds will result in a $20 fee.

☐ **Credit Card:** ○ American Express ○ MasterCard ○ VISA

Card Number | Expiration Date

Signature

Print Name

RETURN BY:

Email: education@prosthodontics.org

Mail: American College of Prosthodontists
5198 Eagle Way, Chicago, IL 60678-5198

Fax: 312-573-1257

On-site registration requires payment via credit card. Cash or check will not be accepted.

By registering for this event, you grant ACP permission to distribute your name and address to all 2019 Annual Session exhibitors for promotional purposes.

By registering for this event, you also grant permission to have photographs taken during the event that may be used for future promotional purposes.

Please retain a copy of both pages of this form for your records.