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: _________________________Email:____________________________

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
admin@wcdental.org

For office use only:

Date Rcvd: ___________ CE Broker: ___________ Calendar: ___________ Mailed: ___________