

**West Coast District Dental Association**  
**Continuing Education Voucher Request**

Name of Course: \_\_\_\_\_

Speaker(s): \_\_\_\_\_

Date(s) of Course: \_\_\_\_\_

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 to this individual)

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

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

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**NUMBER OF VOUCHERS REQUESTED: \_\_\_\_\_ \*\***

\*\*Requests for 100+ vouchers will be sent to an outside printing company and the affiliate will be responsible for payment.

**Return this form to:**

West Coast District Dental Association  
9720 North Armenia Avenue, #F  
Tampa, Florida 33612  
(813) 931-3018 or FAX (813) 931-1851