

**CDAA Fall 2009 Continuing Education
Registration Form**

Name _____ **ADAA/CDA#** _____

Address _____

Telephone _____ **Cell** _____

Email _____

If Dental Assisting Student, school attending: _____

Check courses below you wish to attend:

Course	Member Fee	Non-Member Fee	DA Student
Understanding Dental Patients With Mental Illness Thurs. Sept. 10, 2009 CT Valley Hospital Middletown, CT 6:30pm-8:30pm	\$10 _____	\$20 _____	Free-this course only
CPR Sat. Oct. 17, 2009 CT Children's Medical Center Hartford, CT 9:00am to 1:00pm	\$75 _____	\$85 _____	Deadline for CPR course, postmark Oct.5
TOTAL	_____	_____	

Checks are payable to: CDAA

Mail completed form to:
Lisa Cooper-Smith, CDA
CDA Secretary
36 Haddam Neck Road
East Hampton, CT 06424