Continuing Education Course Validation Request Form for Live Presentations

(Please type or print)

1) Course Title

2) Learning Objectives for Course

3) Course Location (address of where program will be presented- city, state, zip)

4) Date course will be presented

5) Number of hours for course presentation (CEUs) __________

6) Course Type _______ Practice Management ________ Clinical

7) Course Designed for (check all that apply)
   ___ General dentist   ___ Specialist   ___ Hygienist   ___ Assistant   ___ Other

8) Facilitator/Speaker (who will present the course)

9) Credentials of the Speaker (education degrees, certification, etc.)

10) Phone number or e-mail address of speaker

11) Reference for speaker with email or phone contact information
12) Limitation on Number of participants: _______ Yes (how many ________) or _______No

13) List course on MDA website: (no additional cost apply) ___________Yes   ___________No

Program Sponsor Contact Information

Name: _____________________________________________________________

Address: __________________________________________________________________

Phone: ___________________________ E-mail: ___________________________

I certify that the information listed on this application is accurate.

Authorizing Signature: ____________________________________________ Date: _______________________

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Continuing Education Course Validation Fees for Live Presentations

Practice Management Programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>.5 – 4 hours</td>
<td>$100.00 per course</td>
</tr>
<tr>
<td>5 – 8 hours</td>
<td>$200.00 per course</td>
</tr>
</tbody>
</table>

Clinical Programs

<table>
<thead>
<tr>
<th>Duration</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>.5 – 4 hours</td>
<td>$150.00 per course</td>
</tr>
<tr>
<td>5 – 8 hours</td>
<td>$250.00 per course</td>
</tr>
</tbody>
</table>

Please remit completed application and payment by check to the MDA Office.