

# Radiation Safety & Protection Course

\*Cost: \$110.00

Date	Location	Deadline
<input type="checkbox"/> February 7, 2009	Autry Tech Center- <b>Enid</b>	<b>January 19, 2009</b>
<input type="checkbox"/> April 25, 2009	Tulsa Convention Center- <b>Tulsa</b>	<b>April 6, 2009</b>
<input type="checkbox"/> June 13, 2009	Great Plains Area Vo-Tech- <b>Lawton</b>	<b>May 25, 2009</b>
<input type="checkbox"/> July 25, 2009	Indian Capital Vo-Tech- <b>Muskogee</b>	<b>July 6, 2009</b>
<input type="checkbox"/> September 19, 2009	(Location TBA) – <b>Oklahoma City</b>	<b>August 31, 2009</b>
<input type="checkbox"/> December 5, 2009	(Location TBA)- <b>Oklahoma City</b>	<b>November 16, 2009</b>

The Oklahoma Board of Dentistry approves this course. Dental assistants in Oklahoma may expose radiographs only after successfully completing this course, meeting additional Board requirements and obtaining their certificate from them.

**ENROLLMENT FEE:**

**\$110.00 per person. This must be paid in advance. Refunds will only be granted on or before the above enrollment deadline date (minus a \$25.00 administrative fee).** After this date ½ will be refunded. "No shows" will not receive a refund. Make checks payable to the Oklahoma Dental Foundation. Notice must be given by the deadline date to receive a refund. No exceptions. Price increases are subject to ODF Board approval. **NOTICE: A \$20 INCREASE WILL BE APPLIED TO ALL ENROLLMENTS SUBMITTED PAST THE DEADLINE DATE.**

**MAIL PAYMENT WITH THIS APPLICATION TO:**

Attn: Radiation Safety Course  
**Oklahoma Dental Foundation**  
 317 NE 13<sup>th</sup> Street  
 Oklahoma City, OK 73104

If you have questions, call (405) 241-1299. *(Return this entire form)*

**ENROLLMENT:**

**Enrollment will not be accepted after the deadline date above.** Class size is limited. A course manual and enrollment information will be sent to students approximately two (2) weeks prior to the course. **Lunch is included** in the enrollment fee. All courses are subject to change or cancellation due to *Force Majeur* reasons.

**Print legibly or type – List entire address including box or suite number:**

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_

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

Employing Dentist \_\_\_\_\_ Office Phone (\_\_\_\_) \_\_\_\_\_

Office Address \_\_\_\_\_ Suite \_\_\_\_\_

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

School – If Dental Assisting School \_\_\_\_\_

School Phone \_\_\_\_\_

**Non-discriminatory Policy Statement**

It is the policy of this Foundation to provide all of its services and programs to persons of any race, religion, creed, national or ethnic origin and color. The Foundation shall not discriminate on the basis of race, religion, creed, national origin or ethnic origin and color in the administration of any of its programs or services.



**ODF OFFICE USE ONLY**

Date Rcv'd \_\_\_\_\_ Check/CC-AP # \_\_\_\_\_ Amount \_\_\_\_\_ Data Entered \_\_\_\_\_