AUBURN DENTAL ASSISITING PROGRAM REGISTRATION FORM

Please mail, fax or call or payment and registration:
Auburn Dental Assisting Program | 1575 Professional Pkwy | Auburn, AL 36830 | fax 334-821-4322 | phone 334-821-2846

Student Name (please print): ______________________________________DOB: _________

Address: ____

City: ______________________________________State: _________Zip______________

Home Phone #: _______________________ Cell Phone #: ________________________

*Email address: ____
(*this will be where all course work will be sent)

Emergency Contact Name: ____________________________ Phone: _______________

OFFICE USE ONLY

Student # ______

EP Sent ________

Wait List _______

By signing, I acknowledge I have read and understood Auburn Dental Assisting Program's Registration/Refund Policy.

Student Signature: __________________________________Date: _________________

How did you hear about our course?
___ Internet
___Billboard
___Restaurant TV
___Previous Student
____

I wish to enroll in the following session | 2018-2019

____ **Winter Session**	**Saturdays** (January 4 – March 7) Early Enrollment Deadline December 4, 2019
____**Spring Session**	**Saturdays** (March 28 – June 13) Early Enrollment Deadline February 27, 2020
____**Summer Session**	**Fridays** (July 10 – September 18) Early Enrollment Deadline June 10, 2020
____**Fall Session**	**Fridays** (September 25 – December 5) Early Enrollment Deadline August 27, 2020

____ Early Enrollment $2995.00

(if enrolling before Early Enrollment Deadline – see above)
Please check one:
____ $2995 Paid in Full
____ $850 Required Minimum Down Payment
$______ amount if paying more than $850 required Minimum down payment, but less than Full Payment

____ General Enrollment $3850.00

(if enrolling after Early Enrollment Deadline – see above)
Please check one:
____ $3850 Paid in Full
____ $850 Required Minimum Down Payment
$______ amount if paying more than $850 required Minimum down payment, but less than Full Payment

Forms of Payment (Personal Checks are Not Accepted)

Please accurately fill in below:

______ **Cash** – Amount $_________

______ **Cashier's Check/Money Order** – Amount $_________ Check # _________

______ **Credit** – *please circle one*: Credit Card or Care Credit

*a 3.95% convenience fee will be added to all credit card transactions

Credit Card or Care Credit # ____

Credit Card Exp. Date: ____________ Credit Card 3 Digit Security Code: ___________

If paying with **CareCredit,** please select Payment Plan:
☐ 6 Month No Interest ☐ 12Month No Interest

Name on Card/Account: ____

Card / Account Billing Address: ____

City: ______________________________________ State: ______________ Zip: _____________

Card / Account holder Signature: ____