

# SLEEP DISORDERS DENTISTRY

## Seminar Registration Form



Sleep Group Solutions  
16840 NE 19<sup>th</sup> Ave. North Miami Beach, FL 33162  
Phone: 866-353-3936 Fax: 305-405-4008

Email: [sleep@sleepgs.com](mailto:sleep@sleepgs.com)

### **Registration Information**

Desired Course Date: _____	City / State: _____
There will be a total of ____ Doctors and ____ Staff attending	
Attendee Names: _____ _____ _____	
Practice Address _____ _____ _____	
City _____	State _____ ZIP _____
Phone _____	Fax _____
Email _____	

### **Payment Information**

Cost is \$895 per doctor, \$395 per staff member.	
Billing address same as above? Y / N	_____
_____ Visa	_____ Mastercard
Credit Card # _____	Exp. ____ / ____ / ____ CV2 # _____
Cardholder Signature: _____	

**PLEASE FAX COMPLETED FORM TO: 305-405-4008**

**[WWW.SLEEPGS.COM](http://WWW.SLEEPGS.COM)**

Registrations will be processed and charged immediately. Confirmations will be faxed to the number provided