



1009 Spring Forest Road
Raleigh, NC 27615
919-878-2077

FOR OFFICE USE ONLY

Date Received: _____ Term: _____

Program Fee: _____

APPLICATION for NITROUS OXIDE SEDATION COURSE

First Name: _____ Last Name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Current Address: _____
City State Zip

Home #: (_____) _____ Cell #: (_____) _____

E-Mail Address: _____

How did you hear about this program? _____

Have you received any Dental Assisting or Dental Hygiene training? YES NO Which? _____

Where did you attend school/receive training? _____

Year Graduated: _____ Are you currently employed in a dental office? YES NO

In case of emergency who may we contact?

Name: _____ Phone #: (_____) _____ Relationship: _____

Full Address: _____

Course Cost: \$350.00

I understand that the total program fee must be paid in full at the start of the class.

Signature: _____

Date: _____