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LOS ANGELES SCHOOL OF DENTAL ASSISTING
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8-Hour INFECTION CONTROL COURSE
REGISTRATION FORM (V2026)

Name_____

Last Four Digits of SSN: _____ Date of Birth_____

Address_____City_____State_____Zip_____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ E-Mail_____

In case of emergency contact:

Name_____Phone (____) _____Relationship_____

Address_____City_____State_____Zip_____

I wish to be considered for acceptance for the course scheduled on: _____

The fee for the course does not include PPE. It is the candidate's responsibility to bring their own PPE (Head Cap, Face Masks, Face Shield or Eye Protection, Disposable Gowns, Gloves, etc.). A candidate who does not have proper PPE may not be allowed to perform the procedures.

CANCELLATION POLICY:

The fee for this board approved Infection Control Course is \$310 and part of which is a NON-REFUNDABLE processing fee of \$50.00. Any cancellations, regardless of reason, TWO WEEKS PRIOR TO THE START OF THE CLASS WILL RECEIVE NO REFUNDS WHATSOEVER AND THE ENTIRE PAYMENT IS FORFEITED. NO REFUNDS FOR NO SHOWS IN CLASS.

Student's electronic text, actual signature or digital signature below confirms acceptance of all of the above:

Signature_____Date_____