**DR. FERNANDO DE LA PENA DENTAL CORPORATION**
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# RADIATION SAFETY COURSE REGISTRATION FORM (V2025)

Name______________________________________

Social Security Number_________________________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 this course does not include PPE, Sensor Holders, etc.***
***It is the candidate's responsibility to bring their own PPE (Head Cap, Face Masks, Eye Protection or face Shield, 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 Radiation Safety Course (Dental X-Ray Certification) is $499 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.**

Signature_______________________________________ Date_____________________