

DR. FERNANDO DE LA PENA DENTAL CORPORATION
LOS ANGELES SCHOOL OF DENTAL ASSISTING
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RADIATION SAFETY 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 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 \$510 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_____