AMERICAN DENTAL HYGIENISTS' ASSOCIATION™

Registration Form

Please print legibly, incomplete forms will not be accepted. Please provide answers to all questions. Email meetings@adha.net with any questions.

____

Company Affiliation

____

Address City State Zip

Group Registration: Please list the names

1. ____ ❑ Yes______________ ❑ No
   Name Email Address ADHA Member? If Yes, ADHA Member ID#

2. ____ ❑ Yes______________ ❑ No
   Name Email Address ADHA Member? If Yes, ADHA Member ID#

3. ____ ❑ Yes______________ ❑ No
   Name Email Address ADHA Member? If Yes, ADHA Member ID#

4. ____ ❑ Yes______________ ❑ No
   Name Email Address ADHA Member? If Yes, ADHA Member ID#

RDH Investigates, October 19, 2024

Attendee Category –

❑ Member	$149.00
❑ Non-Member	$185.00

Fee Total: $______

Registration Questions

Do you have any dietary allergies? ❑ Yes, ______________________ ❑ No

Will you be attending the Welcome Reception on Friday, October 18th? ❑ Yes ❑ No

Do you recommend Colgate products to patients? ❑ Yes ❑ No

Do you plan to reserve a hotel room? ❑ Yes ❑ No

Do you plan on driving? ❑ Yes ❑ No

How long have you been a dental hygienist? (years) ❑ 0-2 ❑ 3-5 ❑ 6-10 ❑ 11-15 ❑ 16-20 ❑ 21-25 ❑ 26+ ❑ Semi-Retired ❑Retired

Which of the following areas of dental hygiene are you involved in? *(Check all that apply)*

❑ Clinical dental hygiene ❑ Student
❑ Education ❑ DSO
❑ Research ❑ Public Health
❑ Corporate ❑ Self-employed
❑ Administration/management
❑ Other: ______________________

Email: meetings@adha.net

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PAYMENT OPTIONS

Check:

Full registration payment must accompany your registration form. Check and completed form must arrive no later than **October 11, 2024**

Mail checks to:

American Dental Hygienists' Association
ADHA24 Registration
PO Box 809215
Chicago, IL 60680-9215

Credit Card:

Credit Cards will be charged immediately.

❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

____
Card Number

____
Name as it appears on the card.

____
Expiration Date Security Code

Billing Address for Credit Card:

____
Address

____
City State Zip Code

____
Signature

By signing this form: I authorize ADHA's registration company to charge my credit card for the total payment due, acknowledge that the ADHA registration Cancellation policies are in effect.

Email: meetings@adha.net