# 2026 Continuing Education Registration Form

Register Online at **https://delawarestatedentalsociety.org/ce-series.html**

Doctors and staff must register on separate forms. Please duplicate this form for additional enrollments. If forms are mailed together, the complete total may be sent as one check or credit card charge.

COURSE SELECTIONS

## Course Selections – Please check ALL courses/days for which you are registering.

**Visit www.delawarestatedentalsociety.org/ce-series.html for upcoming CE offerings.**

| | DSDS/ADA Member | Non-ADA Member | Staff |
|---|---|---|---|
| ☐ **JANUARY 27, 2026** – **WEBINAR** – Speaker: Louis G. DePaola, DDS "Infection Control is Not Optional. Dental Practitioners Need To Be Involved." | $150 | $150 | $150 |
| ☐ **FEBRUARY 18, 2026** – **WEBINAR** – Speaker: Marvin Leventer, DDS "The Substance Use Disorder Epidemic - What Do We Need To Know?" | $150 | $150 | $150 |
| **GRAND TOTAL** | | | |

## Mark Your Calendar for 2026 CE from Delaware State Dental Society!

**Visit www.delawarestatedentalsociety.org/ce-series.html for more details to come!**

**APRIL 17, 2026** | **MAY 1, 2026 – ANNUAL SESSION** | **OCTOBER 16, 2026** | **NOVEMBER 13, 2026**

REFUNDS

## Refund Policy

All requests for refunds or cancellations must be received in writing no less than two weeks prior to the course. No refunds will be given after that time. Each cancellation and/or refund will incur a $35 administrative fee: Registration funds are non-transferable.

REGISTRANT INFORMATION

## Registration Category – Check One Only

☐ Dentist ☐ Dental Assistant ☐ Dental Hygienist ☐ Office Staff ☐ Dental Resident (Complimentary)

NAME: FIRST_____ MI_____ LAST_____

EMAIL ADDRESS_____
**(REGISTRATION CONFIRMATIONS WILL BE SENT BY EMAIL ONE WEEK PRIOR TO THE COURSE.)**

EMPLOYER'S NAME (STAFF REGISTRATION ONLY)_____

OFFICE ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

OFFICE TELEPHONE_____ CELL PHONE (for emergencies)_____

PAYMENT

## Payment (full payment is due with registration)

Check for $_____ is enclosed payable to **Delaware State Dental Society**.

Charge $_____ to my: ☐ MasterCard ☐ VISA

ACCOUNT NUMBER_____ EXPIRATION DATE_____ SECURITY CODE ON BACK OF CARD_____

## For Information Call: 302-368-7634

Email: dedentalsociety@gmail.com • Website: www.delawarestatedentalsociety.org
Mail: DSDS, 29 Trailwood Drive, Fountain Inn, SC 29644