*Mailing Address ONLY:
8596 Belmont Street, Cypress, CA 90630
www.dentalcareerinstitute.com
E-mail: dentalcareerinstitute@yahoo.com
Business Cell/ Text# (562) 704-2651

IMPORTANT NOTICE: No walk-in's, please. THIS IS NOT OUR CLINICAL OFFICE ADDRESS.

Month/ Day/ Year

Full Name: _____ Date of Birth:_____

Title:_____License No. _____ SSN: _____(last 4 digits Only)

Street Address: _____

City, state and Zip: _____

Home Ph: _____ Cell Ph: _____

Email Address: _____

Course Information

Class Title: _____Option#: _____

Course Fee: $_____ Special Instructions: _____

Form of Payment: _____

Start Date: _____(Leave it blank if TBD)

Important Notice:

We reserve the right to substitute instructors, change class location and class schedule as needed. Any class that does not meet minimum enrollment requirements may be cancelled. We Accept Company Check, Cashier's Check, Money order and Cash.

PAYABLE TO: Dental Career Institute

I am the applicant for this course. I understand all the important notices/ policies and have answered them truthfully & completely. The undersigned waives any liability and legal claims against the school, Dental Career Institute, the instructor, and/or Extramural Facility during the course of this program. In addition, I understand that I need to complete all the course requirements of the program and if I am not able to complete the program on time or according to the due date I automatically fail and will be dropped from the program. If I decide to continue, I must enroll and pay the current fees again.

Student Signature: _____
Date: _____