



# Registration Form

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## Certified Level One Dental Hygiene Expanded Functions Courses

5 Expanded Functions - 2 Day Schedule

LASER DENTISTRY OF IOWA



An Iowa Dental Board  
Approved Course Provider

Date: April or September

Registration Deadline: 1 week prior to course start date

**One registration page per participant. Please print clearly.** (This form may be copied for additional registrations)

Dental Hygienist First & Last Name: \_\_\_\_\_

★ **Eligibility:** Year Graduated from ADA Accredited DH Program: \_\_\_\_\_ Which one? \_\_\_\_\_

First Year Iowa RDH: \_\_\_\_\_ RDH Iowa License #: \_\_\_\_\_ Current? Yes No

Office Name: \_\_\_\_\_ Sponsoring Dentist: \_\_\_\_\_

Contact Address: \_\_\_\_\_ Apt/Unit #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
(for last minute course information &/or changes)

Email (required): \_\_\_\_\_ (you will receive email confirmation of your registration)

### I am registering for:

#### Circle Month of Course

Complete Level 1 RDH Exp. Functions    April    September    29 CEU's    \$300  
(5 Expanded Functions/2 Day schedule - includes all labs and post tests)

### To be completed by the Dental Hygienist:

*I have met all minimum qualifications to participate in Expanded Functions Training as outlined in the Course Eligibility section and indicated above. I understand I must be present for the pre test and lecture in its entirety to gain credit. I also understand that the clinical/lab components of the certification process must be completed under the supervision of my sponsoring dentist and required documentation returned to Impact Dental Training prior to taking the final competency post test. I am solely responsible for meeting all requirements and deadlines of the Iowa Dental Board.*

Hygienist Signature: \_\_\_\_\_

### To be completed by the Sponsoring Dentist:

*The dental hygienist shown above is eligible to participate in the Expanded Function Course. I agree to sponsor her/him for the clinical/ lab component of the certification process and to complete all required documentation accurately.*

DDS Signature: \_\_\_\_\_

**Return registration form and check to:** Impact Dental Training, PO Box 434, Johnston, IA 50131

*Online registration available for credit cards or PayPal. If you have problems, let us know.*

- A \$25 processing fee will be applied to all persons requesting a refund for any reason.
- \$37 charge will be assessed to all returned checks.

★ *Please make sure your are eligible for the course before submitting payment. Inability to take the course due to not meeting eligibility requirements will result in the \$25 processing fee. If you have questions, please contact us prior to registration.*

Internal Use Only:		Scan Date:
Date Received:	Office ID:	Check # :
Email Confirm:    Yes    No	Deposit Date:	Signature: