DENTAL TRADE ALLIANCE ANNUAL MEETING

Hyatt Regency Washington on Capitol Hill
400 New Jersey Avenue NW, Washington, DC 20001

August 11 – August 13, 2009

REGISTRATION FORM

Return this completed form with APPLICABLE Registration Fee(s) to:

DTA
2300 Clarendon Boulevard, Suite1003
Arlington, VA 22201
Phone 703/379-7755
Fax 703/931-9429 or
email to
marydolan@dentaltradealliance.org

One form per Registrant/Family (Please use a separate form for each company employee)

Contact Name:____
Company Name:____
Company Address:____
City:______________________ State/Pr:____________________ Zip:________________
Phone: _______________ Fax:________________ Email:__________________________

Registrant Name:____

Pick 3 Workshops: ☐ **Making Talent** ☐ **Lean** ☐ **Enhancing Sales** ☐ **State of Dental Economy**

Spouse/Guest:____
Child Over 17:____

Children Under 17

Child Name:_____________________ Age:____ Child Name:_____________________ Age:_____
Child Name:_____________________ Age:____ Child Name:_____________________ Age:_____

Note:

1. Forms will not be processed without payment in full. Check or Credit Card Only.

2. DTA dues must be paid in full in order to qualify for the member registration fee.

REGISTRATION FEES		No	Before July 20	After July 20	Total
DTA Member	Primary Attendee		$1,250	$1,350	
DTA Member	Second Attendee (Same Company)		$ 975	$1,075	
DTA Member	Spouse/Guest Includes children over 17		$ 400	$ 500	
Non-Member	Primary Attendee		$1,800	$2,000	
Non-Member	Spouse/Guest		$1,800	$2,000	
DTA Guest	Dental Organization Representative		$ 700	$ 800	
DTA Guest	Dental organization Spouse/Guest		$ 700	$ 800	
Children	(11– 17 years old)		$ 250	$ 350	
Children	(10 and under)		No Charge	No Charge	
			Raffle Tickets! Purchase 5 tickets NOW for $100 **On-Site $25.00 Each**		
				Total	

Cancellations received before **July 20th** entitles registrant to a full refund less a $100 administrative fee. Those received between **July 20th** and **August 3rd** will receive a 50% refund, after **August 3rd** or for no-shows there will be no refund.

METHOD OF PAYMENT	
Check Enclosed $	Credit Card: ☐ American Express ☐ MasterCard ☐ Visa
Card No.	Expiration Date: /
Name on Card:	
Billing Address on Card If Different from Company Address:	
Billing Phone No. on Card If Different from Company Phone No:	
For Credit Card Payments -Email to send copy of receipt:	
For Check Payments –Indicate Method to receive Receipt ☐ Fax ☐ Mail to Company Contact	
Signature (required):	