

**DR. FERNANDO DE LA PENA DENTAL CORPORATION
LOS ANGELES SCHOOL OF DENTAL ASSISTING
DE LA PENA DENTAL GROUP**

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RADIATION SAFETY COURSE REGISTRATION FORM (2024)

Name _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____ E-Mail _____

In case of emergency contact:

Name _____ Phone () _____ Relationship _____

Address _____ City _____ State _____ Zip _____

I wish to be considered for acceptance for the course scheduled on: _____

The fee for this course does not include PPE, X-Ray Films, Film Holders, Film Mounts, etc. It is the candidate's responsibility to bring their own PPE (Head Cap, KN95 Masks, ASTM Level III Face Mask, Face Shield, Disposable Gowns, Gloves, etc.). A candidate who does not have proper PPE may not be allowed to perform the procedures.

CANCELLATION POLICY:

The fee for this board approved Radiation Safety Course (Dental X-Ray Certification) is **\$499** and part of which is a **NON-REFUNDABLE** processing fee of \$50.00. Any cancellations, regardless of reason, **TWO WEEKS PRIOR TO THE START OF THE CLASS WILL RECEIVE NO REFUNDS WHATSOEVER AND THE ENTIRE PAYMENT IS FORFEITED.**

Signature _____

Date _____