



# DENTAL TRADE ALLIANCE ANNUAL MEETING

Hyatt Grand Champions Resort, Villas and Spa  
44-600 Indian Wells Lane, Indian Wells, California 92210

November 2 – 5, 2010

## REGISTRATION FORM

**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: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Spouse/Guest: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Child Name: \_\_\_\_\_ Age: \_\_\_\_\_ Child Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Child Name: \_\_\_\_\_ Age: \_\_\_\_\_ Child Name: \_\_\_\_\_ Age: \_\_\_\_\_

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

DTA  
2300 Clarendon Boulevard  
Suite 1003  
Arlington, VA 22201  
Phone (703) 379-7755  
Fax (703) 931-9429  
or email  
amymoorman@dentaltrade  
alliance.org

**Note:**

- Forms will not be processed without payment in full. Check or Credit Card Only.
- DTA dues must be paid in full in order to qualify for the member registration fee.

<u>REGISTRATION FEES</u>		<u>Number</u>	<u>Fee</u>	<u>Early Bird Special</u>	<u>Total</u>
DTA Member	Primary Attendee		\$1,600		
DTA Member	Additional Attendee (Same Company)		\$1,300		
DTA Member	Spouse/Guest		\$ 650		
Non-Member	Primary Attendee		\$2,500		
Non-Member	Spouse/Guest		\$2,500		
DTA Guest	Dental Organization Representative		\$1,000		
DTA Guest	Dental organization Spouse/Guest		\$1,000		
Children	(12 and over)		\$ 650		
Children	(11 and under)		No Charge	No Charge	
				<u>DTA Foundation Raffle Ticket</u>	
				<b>Total</b>	

**Cancellations** received before **Oct 12<sup>th</sup>** entitles registrant to a full refund less a \$100 administrative fee. Those received between **Oct 12<sup>th</sup>** and **Oct 27<sup>th</sup>** will receive a 50% refund; after **Oct 27<sup>th</sup>** or for no-shows there will be no refund.

<u>METHOD OF PAYMENT</u>	
Check Enclosed: \$	Credit Card: <input type="checkbox"/> American Express <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa
Card No:	Expiration Date: /
Name on Card:	
Billing Address of Card:	
Billing Phone No. of Card:	
For Credit Card Payments -Email to send copy of receipt:	
For Check Payments -Indicate Method to receive receipt <input type="checkbox"/> Fax <input type="checkbox"/> Mail to Company Contact	
Signature (required):	