

REGISTRATION FORM



Advanced Implant Training Program

Information

Complete Name _____

Hospital /Clinic _____ Division / Department _____

Position /Title _____ Degree _____

P.O. Box _____ Postal Code _____ City Code _____

City Address _____

Mobile _____ Telephone _____ Fax _____

Email Address _____

Training Fee for Basic Course : **SR 10,000.00**

Payment Information (Registration forms received without payment won't be processed)

Payment Type : Check Visa Master Card Cash

Cardholder's Name _____

Card Number _____

Registration must be accompanied by payment. Please make your Bank Drafts / Checks payable to:

Bank Name : **SAMBA BANK**
Account Name : Riyadh Colleges of Dentistry & Pharmacy
Account No. : SA944 000 000 000 2600956808

You may fax this form to +966(01)2935430 together with your payment slip or email at **implant@riyadh.edu.sa** or visit Riyadh Colleges of Dentistry & Pharmacy, Olaya Campus.

For more Information please contact:

Tel. No.: +966 (1) 2931177 ext 228/146

Fax No.: +966 (1) 2935430

Email Address: implant@riyadh.edu.sa

visit our website www.riyadh.edu.sa/implant