

# THE JP INSTITUTE

## Mastership Certification Program Registration Form

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Course Location: \_\_\_\_\_ Course Number: \_\_\_\_\_

Name / Title	Tuition	Scholarship*	Tuition	Total Tuition
DDS-#1	\$2795	-\$500	<input type="checkbox"/> \$2295	
DDS-#2	\$2695		\$2695	
RDH-#1	\$2795	-\$1000	<input type="checkbox"/> \$1795	
RDH-#2	\$2695		\$2695	
RDH-#3	\$2595		\$2595	
DA -#1	\$1495		\$1495	
DA -#2	\$1395		\$1395	
DA- #3	\$1295		\$1295	
OM/FO -#1	\$1495		\$1495	
OM/FO-#2	\$1395		\$1395	
<i>Retainer of \$500/person to enroll</i> <i>Balance due 30 days prior to course date</i>	\$500	Total Tuition Less-Retainer Balance Due		

**\*Contact The JP Institute for Information on requirements and Scholarship Applications**

Payment Type:  Check  MasterCard  Visa  American Express

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_ Amount to be charged: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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