**CEU Transcript Request and Duplicate Radiology Certificate Request Form**

Please provide the following information:

Name:____________________________________________________

Address:__________________________________________________

Phone:___________________________________________________

e-mail___________________________________________________

**For Transcripts:** Reporting period requested:___________________________

**For Duplicate Radiology Certificate**: Date of Course_______________________

| | | |
|---|---|---|
| **Fee** | **CEU Transcript for Non-Registry members** | **$100** |
| **Fee** | **Replacement Radiology Certificate** | **$35** |

**You will be informed if a radiology certificate or transcript is available.**

**Payment is required before the transcript is mailed.**

**Please return this form either by fax, e-mail or mail.**

Fax: 508-449-6150

e-mail: skarp@massdental.org

Mail: Continuing Education Department
Massachusetts Dental Society
Two Willow Street, Suite 200
Southborough, MA 01745

For further assistance, please call 508-449-6050 or e-mail skarp@massdental.org

Thank you