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St. Joseph's Health
ST. JOSEPH'S UNIVERSITY
MEDICAL CENTER

REGISTRATION FORM

Administered by:



ACLS Recertification Program

NAME: _____ ☐ **DMD** ☐ **DDS** ☐ **other**

Practice Name: _____

Home Address: _____

AGD # _____ **ADA #** _____ **Permit #** _____

PHONE: _____ **CELL:** _____

FAX: _____ **E-MAIL:** _____

COSTS: ACLS Recertification \$650

**Circle Choice: Course Dates - April 25 - 26, 2026
or in fall: October - 24- 25, 2026**

Recertification Program - ACLS

PLEASE INCLUDE A COPY OF YOUR LICENSE WITH YOUR APPLICATION

NEGATIVE PPD (TB) TEST (less than 1 year old)

Course materials, travel directions and lodging information will be sent
upon receipt of registration.

JOSEPH PORTALE, DMD, MAGD

ASAASD, EXECUTIVE SECRETARY

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