POAM
PRACTICAL ORTHODONTICS
ACADEMY OF MENTORSHIP

REGISTRATION FORM

First Name: _____ Surname: _____ Age: _____

Country: _____ City: _____

Tel: _____ E-mail: _____ Website: _____

Qualification: _____ No. of Years in Practice: _____

Institution: _____

Clinical Experience in Orthodontics:

Courses Previously Attended: _____

Own Patients Treated Using: Removable Appliances: _____ Fixed Appliances: _____ Both: _____

Applying for: ☐ POAM Mentorship Program ☐ POAM **PLUS** Mentorship Program

Reasons for Wanting to Learn Comprehensive Orthodontics on an Advanced Level:

_____

_____

_____

I_____ understand and accept the terms and conditions as set out in the disclaimer notice. Signature:_____ Date: _____

Important notice: The number of mentees registered at any point in time will be limited. Prospective mentees may be placed on a waiting list.

Please e-mail form together with a recent close-up photo to drzieg@poam.co.za