LOUISIANA DENTAL ASSOCIATION
RADIOGRAPHICS ORDER FORM

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(see below)

Date: _____

Name of Person(s) Taking the Test: 1._____ 4._____
(As the name should appear on Certificate)
(Please print) 2._____ 5._____
3._____ 6._____

Office Mailing Address for Certificates:
1. _____

Employed by: Dr. _____ Phone: _____
(Please print)
Address: _____ City_____ Zip_____

PLEASE CHOOSE FORMAT: ☐ **VHS TAPE** ☐ **CD-ROM** ☐ **DVD**

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