ACADEMY OF
DENTAL LEARNING
& OSHA TRAINING

Organizational Billing Information Form and Agreement

Organization Name: ____

Address for Billing Invoice: ____

____

____

Physical Address: ____

(if different than above) ____

Primary Contact Name: ____

Title: ____

Phone: ____

Fax: ____

Email: ____

Secondary Contact Name: ____

Title: ____

Phone: ____

Fax: ____

Email: ____

Preferred Username: ____
(To view employee/student reports.)

Preferred Password : ____
(To view employee/student reports.)

Preferred Registration Password: ____
(For employees/students to bypass payment screen)

ACADEMY OF DENTAL LEARNING & OSHA TRAINING

I ____ herby confirm that I am
(print name)

Authorized by ____
(organization name)

to enter into an employer billing agreement with The Academy of Dental Learning and OSHA Training, LLC.

I understand that by signing this form I am authorizing The Academy of Dental Learning and OSHA Training, LLC.

to invoice ____ for
(organization name)

continuing education courses used by our employees.

____
(signature) (date)

____
(Print title)

Please complete, sign and return to The Academy of Dental Learning and OSHA Training, LLC. via
Mail: POB 14585, Albany, NY 12212
Fax: 518.514.1103
Email: cesupport@dentallearning.org