TMJ & Sleep Therapy Centre
INTERNATIONAL

Dr. Steven Olmos
DDS
Founder, TMJ & Sleep Therapy Centre
DABDSM, DABCDSM, DABCP

Dr. Kristina Wolf
MS, DMD
Adjunct Professor
DABDSM

Anaheim, CA

2024 FALL MINI RESIDENCY

SLEEP-RELATED BREATHING DISORDERS & CRANIOFACIAL PAIN FOR ADULTS & CHILDREN

SESSION 1
SEPT. 6-7, 2024

SESSION 2
OCT. 4-5, 2024

SESSION 3
NOV. 15-16, 2024

COURSE OBJECTIVES

SESSION 1
Learn how to screen for SBD & craniofacial pain
Find CR
Interpret CBCT
Preform and read JVA
Understand head and next anatomy
Understand neuroanatomy
Diagnose and treatment plan

SESSION 2
Evaluate sleep disorders
Triage sleep appliance therapy
Understand different types of headaches
Recapture discs
Chose orthotic design
Understand pharmacology

SESSION 3
Understand how sleep disorders can cause TMJ pain
Understand neuropathic disorders
Understand typical and atypical neuralgias
Understand physical medicine modalities
Create nutrition plans
Use Myofunctional therapies

Live New Patient Exam Every Session

MNRT
NOV. 17-18, 2024
Proper diagnosis is 95% of effective treatment.

48 Hours Lecture & Participation CE

REGISTER TODAY!

www.tmjtherapycentre.com
Or speak directly with our Education Administrator
877.865.4325 / 619.462.0676
OPEN TO ALL MEDICAL PROFESSIONALS. NO PREREQUESITE REQUIRED.

TMJ & Sleep Therapy Centre
INTERNATIONAL

2024 SPRING MINI RESIDENCY
SLEEP-RELATED BREATHING DISORDERS & CRANIOFACIAL PAIN FOR ADULTS & CHILDREN
Anaheim, CA

2024 MINI RESIDENCY COURSE REGISTRATION

Fax: (619) 469-4524 | Email: education@tmjtherapycentre.com

Doctor Name(s): _____

Staff Name(s): _____

Address: _____ **City:** _____

Province/State: _____ **Postal/Zip Code:** _____ **Country:** _____

Email: _____

Office Phone: _____ **Cell Phone:** _____

☐ **SESSION 1 SEPT. 6-7, 2024**
Dentist Course Fee $2195 per session
* Partner and Associate DDS/DMD

☐ **SESSION 2 OCT. 4-5, 2024**
MD, DO, DC, PT Course Fee $1695 per session

☐ **SESSION 3 NOV. 15-16, 2024**
Staff Course Fee $950 per session

		FOR OFFICE USE ONLY
Dentist Fee $2195 x _____ Sessions	$_____	$_____
MD, DO, DC, PT Fee $1695 x _____ Sessions	$_____	$_____
Staff Fee $950 x _____ Staff x _____ Sessions	$_____	$_____
DISCOUNT CODE: _____	$_____	$_____
TOTAL COURSE FEE	**$**_____	**$**_____

PAYMENTS
By signing below, I agree to the following terms: I, the above named, agree to pay T&S Therapy Centre International the full fee as outlined above for the listed course. I understand that T&S International is a United States based company and that all fees are payable in US dollars. If your payment is made in a currency other than USD, the current exchange rate will be applied for each payment. I also understand that if paid in a different currency, a foreign exchange fee may be applied by my merchant and that T&S International is not responsible for that fee.

Please Select One Option:

☐ I authorize my credit card to be charged the first session fee upon receipt of registration form. Subsequent payments will be due 30 days in advance of the course.

☐ I authorize a one time charge on my credit card for the entire amount for my registration of the **3 Sessions of the Mini Residency Course.**

PLEASE CHOOSE: ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** ☐ **AMERICAN EXPRESS**

Card Number: _____ **Exp. Date:** _____ **CV2 Code:** _____

Billing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Name on Card:** _____

Cancellation Policy: All refunds will be issued via USD check from our corporate office, regardless of how the payment was made. Cancellations must be made in writing or over email 30 days before the start of the program listed on this registration form and will be refunded in full less 10% of the fees collected. We are unable to offer refunds within 30 days of a session due to non-refundable commitments. if the event that you cannot attend a session, arrangements can be made to attend the missed session at a later date. In the unlikely event that T&S Therapy Centre International cancels this program, all paid registration fees will be refunded in full within 21 days following the scheduled date of the event.

Please initial here to confirm that you have read and agree to the cancellation policy. _____

I understand, accept and acknowledge that this agreement made this _____ day of _____, _____ to be in effect and binding as of said date of signing.

Print Name: _____ Signature: _____

Referred by: _____

FOR OFFICE USE ONLY

Invoice # _____ Sales Order # _____ PIF# _____