

CCF EMPLOYEE REGISTRATION FORM

Course Name: Pulmonary Hypertension Summit 2007
Course Number: 011463
Course Date: November 16-17, 2007
Location: InterContinental Hotel & Bank of America Conference * Cleveland, OH

CCF Employee (includes) CCF Main Campus, CCF Children's Hospital for Rehabilitation, Beachwood, Brunswick, Chagrin Falls, Elyria, Independence, Lakewood, Lorain, Solon, Strongsville, Westlake, Willoughby Hills, Wooster, Ft. Lauderdale/Weston, Anesthesia Department personnel at Huron, Hillcrest, Euclid, Marymount and Lutheran

<input type="checkbox"/> CCF Staff Physician (MD/PhD) (includes syllabus, continental breakfasts, breaks, lunches and reception) <input type="checkbox"/> I require vegetarian lunches. <input type="checkbox"/> I will attend the reception. <input type="checkbox"/> Full Course - \$150 <i>or</i> Per Day \$110.00 Friday \$110.00 Saturday
<input type="checkbox"/> CCF Resident <input type="checkbox"/> CCF Fellow <input type="checkbox"/> CCF Nurse <input type="checkbox"/> CCF Physician Assistant <input type="checkbox"/> CCF Other _____ (includes syllabus, continental breakfasts, breaks, lunches and reception) <input type="checkbox"/> I require vegetarian lunches. <input type="checkbox"/> I will attend the reception. <input type="checkbox"/> Full Course - \$100 <i>or</i> Per Day \$85.00 Friday \$85.00 Saturday

Check here if you have any special needs that require additional assistance. A CME staff member will contact you to discuss your special requirements.

CCF and CCHS Pharmacists who are registering for this course and would like to receive Ohio Pharmacy Credit for their attendance need to contact the CCF Pharmacy Department, Morton P. Goldman, at (216) 444-1127 to have this course considered for Pharmacy credit at least 10 days prior to the course date.

Please Print:

Name: _____ Degree (initials): _____

Hospital Affiliation: _____ Department Name: _____

Last four (4) digits of SSN: _____ CCF Employee Number: _____ Mail Code: _____

CCF Phone: _____ CCF FAX: _____ Home Phone Number: _____

Mailing Address _____ City/State/ZIP _____

Specialty: _____ Email: _____

Charge the following credit card: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____ 3 digit code on back of card _____

Total Charge: _____

Signature: _____ Date: _____

(not valid without signature)

Charge the following CCF Lawson Account: CCF Department Account Number _____

Signature _____
Administrator

Credit card or Dept. Account Number payment may be expedited by completing and faxing this form to: (216) 445-9406 or Mail check and registration form to: The Cleveland Clinic Foundation, P. O. Box 931653, Cleveland, OH 44193-1082