

CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: 011579
Course Name: Blood Management Summit
Course Date: October 13, 2008
Location: InterContinental Hotel & Bank of America Conference Center * 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

CCHS Hospitals: Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, South Pointe

CCHS Affiliates: Grace Hospital, Ashtabula County Medical Center

Registration fee includes syllabus, continental breakfasts, refreshment breaks, lunch and reception.

<input type="checkbox"/> CCF Staff Physician	<input type="checkbox"/> CCHS Physician	\$240.00
<input type="checkbox"/> CCF Resident	<input type="checkbox"/> CCHS Resident	\$180.00
<input type="checkbox"/> CCF Nurse	<input type="checkbox"/> CCHS Nurse	\$180.00
<input type="checkbox"/> CCF Other _____	<input type="checkbox"/> CCHS Other _____	\$180.00

___ I will attend reception on Monday, 7:00pm

___ I require vegetarian meals.

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

Please Print:

Name: _____ Degree (initials): _____

Hospital Affiliation: _____ Department Name: _____

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

CCF Phone: _____ CCF FAX: _____ Mail Code: _____

Mailing Address _____ City/State/ZIP: _____

Home Phone Number: _____ Email: _____

Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____

3 / 4 digit v-code located on back of card _____ Total Amount to be Charged: _____

Signature: _____ (Not valid without signature)

CCF/CCHS Cost Center Number _____ Signature _____
Administrator

Credit card or cost center 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