

CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: 020515
Course Name: 36th Annual Dermatopathology Self-Assessment Workshop
Course Date: October 4, 2008
Location: Cleveland Clinic Lerner Research Institute * Cleveland, OH

CCF Employee: 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 and 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 breakfast, breaks and lunch.

		<u>Registration Fee</u>
<input type="checkbox"/> CCF Staff Physician (MD/PhD)	<input type="checkbox"/> CCHS Physician	\$190.00
<input type="checkbox"/> CCHS Physician Physician Organization		\$190.00
<input type="checkbox"/> CCF Resident	<input type="checkbox"/> CCF Fellow	\$ 75.00
<input type="checkbox"/> CCHS Resident	<input type="checkbox"/> CCHS Fellow	
<input type="checkbox"/> CCF Nurse	<input type="checkbox"/> CCHS Nurse	
<input type="checkbox"/> CCF Other _____	<input type="checkbox"/> CCHS Other _____	
<input type="checkbox"/> I request a vegetarian lunch. <input type="checkbox"/> I would like to rent a microscope. An additional \$239.00 is enclosed.		

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 Address: _____

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)

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