

# CCF EMPLOYEE REGISTRATION FORM

**Course Number:** 011546  
**Course Name:** Diabetes Day 2008: The Lifecycle of Diabetes  
**Course Date:** May 2, 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

<input type="checkbox"/> CCF Staff Physician (MD/PhD)	<input type="checkbox"/> CCF Dietician	<input type="checkbox"/> CCF Nurse
<input type="checkbox"/> CCF Other _____		
\$100.00 – Registration fee ( includes attendance, syllabus, continental breakfast, lunch and breaks)		
<input type="checkbox"/> I request vegetarian lunch.		
<input type="checkbox"/> CCF Resident	<input type="checkbox"/> CCF Fellow	
\$125.00 – Registration fee ( includes attendance, syllabus, continental breakfast, lunch and breaks)		
<input type="checkbox"/> I request vegetarian lunch.		

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: \_\_\_\_\_ Specialty: \_\_\_\_\_  
CCF Phone: \_\_\_\_\_ CCF FAX: \_\_\_\_\_ Mail Code: \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

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 Department Account 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**