CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: **011533**
Course Name: **A Hands-On Approach to Diagnostic Pathology - May 17-18, 2008**
Location: **InterContinental Hotel & Bank of America Conference Center * 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
***Hospital Affiliation*:** 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.

☐ CCF Staff Physician (MD/PhD) ☐ CCHS Physician	$400.00
☐ CCHS Physician Physician Organization	$240.00
☐ CCF Resident / ☐ CCHS Resident / ☐ CCF Fellow / ☐ CCHS Fellow	$150.00
☐ CCF Nurse / ☐ CCHS Nurse / ☐ CCF Allied Health Professional / ☐ CCHS Allied Health Professional	$150.00

___ I will attend Saturday Wine & Cheese Reception. ____ 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 Address:___________________________________

Workshop and Session Sign-up

Saturday, May 17, 2008 (9:30 am – 12:30 pm)	___ Workshop I	**or**	___ Workshop II				
Saturday, May 17, 2008 (2:00 pm – 3:15 pm)	☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	
Saturday, May 17, 2008 (3:45 pm – 5:00 pm)	☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	☐ G
Sunday, May 18, 2008 (8:30 am – 9:45 am)	☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	
Sunday, May 18, 2008 (10:15 am – 11:30 am)	☐ A	☐ B	☐ C	☐ D	☐ E		

Charge the following account**:** ☐**VISA** ☐ **MASTERCARD** ☐ **DISCOVER** ☐ **AMERICAN EXPRESS**

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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 <u>and</u> registration form to: The Cleveland Clinic Foundation, P. O. Box 931653, Cleveland, OH 44193-1082