

CCF EMPLOYEE REGISTRATION FORM

Course Number: 011536
Course Name: Advances in Gynecologic Surgery 2008
Course Date: May 15-17, 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 and Anesthesia Department personnel at Huron, Hillcrest, Euclid, Marymount and Lutheran

Registration fee includes syllabus, continental breakfasts, breaks, lunches and reception.

- CCF Staff Physician (MD/PhD) \$100
 CCF Resident CCF Fellow CCF Nurse CCF Other _____ \$ 50
 I will attend Symposium Reception on Thursday, May 15th at 5:45 pm.
 My Guest(s) will attend Symposium Reception on Thursday, May 15th at 5:45 pm. _____ x \$65.00/person
 I request vegetarian lunches.

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: _____ 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