CLEVELAND CLINIC HEALTH SYSTEM
EMPLOYEE REGISTRATION FORM

Course Number/Name: **011536**
Course Name: **Advances in Gynecologic Surgery 2008**
Course Date: **May 15-17, 2008**
Location: **InterContinental Hotel & Bank of America * Cleveland, OH**

CCHS Health System: Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, South Pointe
CCHS Affiliates: Grace Hospital, Ashtabula County Medical Center

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

☐ **CCHS Physician** **$600**
☐ **CCHS Physician Organization (CCHS PO)** **$450**
☐ **CCHS Resident** ☐ **CCHS Fellow** ☐ **CCHS Nurse** ☐ **CCHS Other**__________________________ **$400**

☐ I will attend Symposium Reception on Thursday, May 15, 2008 at 5:45 pm
☐ My Guest(s) will attend Symposium Reception on Thursday, May 15, 2008 at 5:45 pm ______ x $65/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:____ Last four (4) digits of SSN:__________

Mailing Address:___________________________________City/State/Zip:___________________________

Home Phone:_______________________ Business Phone:________________________ Fax Number:___________

Email address____ Specialty:___________________________________

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

Credit Card Number:________________________ Expiration Date:_______ 3 digit code on back of card_____

Total Charge:_____________

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