

CCF EMPLOYEE REGISTRATION FORM

Course Number: 020498
Course Name: 21st Century Treatment of Heart Failure
Course Date: October 16-18, 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 social events.

CCF Staff Physician
 Full Registration - \$100.00 OR
Per Day: **Friday \$60.00** **Saturday \$60.00**

CCF Resident **CCF Fellow** **CCF Nurse**
 CCF Physician Assistant **CCF Perfusionist** **CCF Other Employee** _____

Full Registration - \$50.00 OR
Per Day: **Friday \$30.00** **Saturday \$30.00**

Yes, I will be attending the poster session and reception on Friday, 5:30 – 7:00 pm.

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: _____ Email 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 _____
Total Amount to be Charged: _____

Signature: _____ (Not valid without signature)

CCF Department Cost Center _____ 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