

**CLEVELAND CLINIC HEALTH SYSTEM  
REGISTRATION FORM**

**Course Number:** 020498  
**Course Name:** 21<sup>st</sup> Century Treatment of Heart Failure  
**Course Date:** October 16-18, 2008  
**Location:** InterContinental Hotel & Bank of America Conference Center \* Cleveland, OH

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

Registration includes syllabus, continental breakfasts, breaks, lunches and social events.			
<input type="checkbox"/> CCHS Physician			
<b>Full Registration</b>	<input type="checkbox"/> \$280.00	<b>OR</b>	
<b>Per Day</b>	<input type="checkbox"/> Friday \$160.00	<input type="checkbox"/> Saturday \$160.00	
<input type="checkbox"/> CCHS Fellow	<input type="checkbox"/> CCHS Resident	<input type="checkbox"/> CCHS Nurse	<input type="checkbox"/> CCHS Physician Assistant
<input type="checkbox"/> CCHS Perfusionist	<input type="checkbox"/> CCHS Other _____		
<b>Full Registration</b>	<input type="checkbox"/> \$50.00		
<b>Per Day</b>	<input type="checkbox"/> Friday \$30.00	<input type="checkbox"/> Saturday \$30.00	
<input type="checkbox"/> Yes, I will be attending the poster session/reception on Friday, 5:30 – 7 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: \_\_\_\_\_ 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  
Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ 3 / 4 digit v-code \_\_\_\_\_  
Total Amount to be Charged: \_\_\_\_\_

Signature: \_\_\_\_\_ (Not valid without signature)

CCHS 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**