

CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: 020521
Course Name: Music and the Brain Registration
Course Date: June 6, 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

Fee includes syllabus, continental breakfasts, lunch, refreshment breaks and evening gala..

- | | |
|--------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> CCF Physician - \$75.00 | <input type="checkbox"/> CCHS Physician - \$75.00 |
| <input type="checkbox"/> CCF Resident - \$50.00 | <input type="checkbox"/> CCHS Resident - \$50.00 |
| <input type="checkbox"/> CCF Fellow - \$50.00 | <input type="checkbox"/> CCHS Fellow - \$50.00 |
| <input type="checkbox"/> CCF Student - \$50.00 | <input type="checkbox"/> CCHS Student - \$50.00 |
- I will attend the evening gala at Mixon Hall. I will attend luncheon.

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, Pharm.D., 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: _____
Work Phone: _____ Work FAX: _____ Mail Code: _____
Mailing Address: _____ City/State/ZIP: _____
Home Phone Number: _____ Email _____

Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____
Total Amount to be Charged: _____

Signature: _____ 3/ 4 digit v-code _____
(Not valid without signature) (located on back of card)

CCF Cost Center Number _____ Signature _____
Administrator

Credit card payment or cost center number 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