

**CLEVELAND CLINIC HEALTH SYSTEM  
EMPLOYEE REGISTRATION FORM**

**Course Number:** 011543  
**Course Name:** Nephrology Update 2008/Cardio Renal Summit  
**Course Date:** October 4-7, 2008  
**Location:** Ritz Carlton Hotel \* Cleveland, OH

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

**CCHS Staff Physician: Full Course (Oct. 4-7) - \$639.00**  
(includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**PER DAY FEES:** (includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**Days Attending:**  **Saturday only (Oct. 4) –Cardio Renal Summit -\$140.00**

**OR**  **Sunday-Tuesday (Oct. 5-7) - Nephrology Update - \$559.00**

- I require vegetarian lunches.  I will attend the welcome reception.  
 \$40.00 additional - I would like to purchase the CD ROM of the final presentations

**CCHS Resident**  **CCHS Fellow**  
 **CCHS Nurse**  **CCHS Other Employee** \_\_\_\_\_

(includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**Full Course (Oct. 4-7) - \$300.00**

**PER DAY FEES:** (includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**Days Attending:**  **Saturday only (Oct. 4) –Cardio Renal Summit -\$60.00**

**OR**  **Sunday-Tuesday (Oct. 5-7) - Nephrology Update - \$280.00**

- I require vegetarian lunches.  I will attend the welcome reception.  
 \$40.00 additional - I would like to purchase the CD ROM of the final presentations

Check here if you have any special needs that require additional assistance. A CME staff member will contact you to discuss your special requirements.

**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 \_\_\_\_\_ Specialty: \_\_\_\_\_

**WORKSHOP SIGN-UP (Please indicate your choice)**

Sunday Workshop Choice  A or  B  
Monday Workshop Choice  C or  D

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

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Total Amount to be Charged: \_\_\_\_\_

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

CCHS Cost Center Number \_\_\_\_\_ Signature \_\_\_\_\_

Administrator

**Credit card payment 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**