

CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: 020487
Course Name: Cleveland Spine Review – Hands-On 2008
Course Date: July 16-22, 2008
Location: Embassy Suites Hotel * Independence, 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

No Charge (includes syllabus, continental breakfasts, lunches, refreshment breaks and Social Events.

- | | | |
|--|--|--|
| <input type="checkbox"/> CCF Staff Physician (MD/PhD) | <input type="checkbox"/> CCF Resident | <input type="checkbox"/> CCF Fellow |
| <input type="checkbox"/> CCF Physician Assistant | <input type="checkbox"/> CCF Nurse | <input type="checkbox"/> CCF Other _____ |
| <input type="checkbox"/> CCHS Staff Physician (MD/PhD) | <input type="checkbox"/> CCHS Resident | <input type="checkbox"/> CCHS Fellow |
| <input type="checkbox"/> CCHS Physician Assistant | <input type="checkbox"/> CCHS Nurse | <input type="checkbox"/> CCF Other _____ |

- Additional tickets for social activities may be purchased:
- | | | |
|---|------|-----------------------|
| <input type="checkbox"/> Opening Reception | \$35 | # extra tickets _____ |
| <input type="checkbox"/> Crawfish Boil Dinner | \$35 | # extra tickets _____ |
| <input type="checkbox"/> Rock Hall Reception | \$65 | # extra tickets _____ |
| <input type="checkbox"/> Bowling Night | \$25 | # extra tickets _____ |

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: _____ Department Name: _____
Last four (4) digits of SSN: _____ CCF Employee Number: _____ Specialty: _____
CCF Phone: _____ CCF FAX: _____ Mail Code: _____
Mailing Address: _____ City/State/ZIP: _____
Home Phone Number: _____ Email: _____

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)

Credit card 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