

CCF EMPLOYEE REGISTRATION FORM

Course Number: 011557
Course Name: Leadership Development for Women in Health Care Professions - 2008
Course Date: September 24-25, 2008
Location: InterContinental Hotel and 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 includes syllabus, continental breakfast, lunch, refreshment breaks, dinner and reception.

- | | | |
|---|---|--|
| <input type="checkbox"/> CCF Staff Physician
Registration fee is \$200.00 | <input type="checkbox"/> CCF Nurse | <input type="checkbox"/> CCF Other Employee _____ |
| <input type="checkbox"/> CCF Resident
Registration fee is \$35.00 | <input type="checkbox"/> CCF Fellow | <input type="checkbox"/> CCF Student |
| <input type="checkbox"/> I require a vegetarian lunch. | <input type="checkbox"/> I will attend the Reception on Thursday, Sept.25 | |
| <input type="checkbox"/> I will attend the Dinner Buffet on Wednesday, Sept.24 | | |

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 _____ 3/4 digit V-code (located on back of card) _____ Expiration Date _____

Total Amount to Charge _____

Signature _____ (Not valid without signature)

CCF Cost Center Number _____ 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: Cleveland Clinic Foundation, P. O. Box 931653, Cleveland, OH 44193-1082