

**CLEVELAND CLINIC HEALTH SYSTEM  
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 & 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 breakfast, breaks, lunch, dinner buffet and reception.			
<input type="checkbox"/> CCHS Physician	<input type="checkbox"/> CCHS Nurse	<input type="checkbox"/> CCHS Physician Assistant	
<input type="checkbox"/> CCHS Other _____		<input type="checkbox"/> \$200 Registration	
<input type="checkbox"/> CCHS Fellow	<input type="checkbox"/> CCHS Resident	<input type="checkbox"/> CCHS Student	<input type="checkbox"/> \$35 Registration
<input type="checkbox"/> I request a vegetarian lunch.	<input type="checkbox"/> I will attend the reception, Thursday, Sept. 25		
<input type="checkbox"/> I will attend the dinner buffet, 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: \_\_\_\_\_ Last four (4) digits of SSN: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Email \_\_\_\_\_ Specialty \_\_\_\_\_

Charge the following account:  VISA  MASTERCARD  DISCOVER  AMERICAN EXPRESS

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ 3/4 digit v-code \_\_\_\_\_  
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: The Cleveland Clinic Foundation, P. O. Box 931653, Cleveland, OH 44193-1082**