

**Cleveland Clinic and Cleveland Clinic Health Systems
EMPLOYEE REGISTRATION FORM**

Course Number: 020506
Course Name: Ethical Challenges in Surgical Innovation
Course Date: May 8-9, 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

Registration includes syllabus, continental breakfasts, lunches and refreshment breaks

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|--|--|--|
| <input type="checkbox"/> CCF Staff Physician | <input type="checkbox"/> CCHS Physician | <input type="checkbox"/> \$200 Registration Fee |
| <input type="checkbox"/> CCF Nurse | <input type="checkbox"/> CCHS Nurse | <input type="checkbox"/> \$50 Registration Fee |
| <input type="checkbox"/> CCF Resident <input type="checkbox"/> CCHS Resident | <input type="checkbox"/> CCF Fellow <input type="checkbox"/> CCHS Fellow | |
| <input type="checkbox"/> CCF Other _____ | <input type="checkbox"/> CCHS Other _____ | |
| <input type="checkbox"/> CCF Student | <input type="checkbox"/> CCHS Student | <input type="checkbox"/> Complimentary – LUNCH
NOT INCLUDED |

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: _____

CCF Phone: _____ CCF FAX: _____ Mail Code: _____

Mailing Address: _____ City/State/ZIP CODE _____

Home Phone Number: _____ Email _____

Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____ 3 digit v-code _____

Total Amount to be Charged: _____

Signature: _____ (Not valid without signature)

CCF Department Account Number _____ Signature _____
Administrator

Credit card or Dept. Account 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