

CCF EMPLOYEE REGISTRATION FORM

Course Number: 020510
Course Name: Update in Headache Management
Course Date: May 30, 2008
Location: Bunts Auditorium, Cleveland Clinic * 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 Fee = \$80 (includes syllabus, continental breakfast, refreshment breaks and lunch)

- CCF Staff (MD/PhD) CCF Fellow CCF Resident CCF Nurse
 CCF Nurse Practitioner CCF Physician Assistant CCF Other Employee _____
 I am a member of the Ohio Headache Association.
 I require a vegetarian lunch.

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, 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: _____
Home Phone Number: _____ Email: _____

Workshop/Breakout Sessions (choose only one) 1:45 pm

- A – Taking Headache History or B – Temporomandibular Disorders

Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____

3/4 digit v-code located on back of card _____ Total Amount to be Charged: _____

Signature: _____ (Not valid without signature)

Charge the following CCF Lawson Account: CCF Department Account Number _____

Signature _____ (Administrator)

Credit card or Dept. Account Number 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