

**CLEVELAND CLINIC HEALTH SYSTEM
EMPLOYEE REGISTRATION FORM**

Course Number/Name: 020510
Course Name: Update in Headache Management
Course Date: May 30, 2008
Location: Bunts Auditorium, Cleveland Clinic * 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, break and lunch.

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|---|-------|
| <input type="checkbox"/> CCHS Physician | \$160 |
| <input type="checkbox"/> CCHS Physician Organization (CCHS PO) | \$120 |
| <input type="checkbox"/> CCHS Resident <input type="checkbox"/> CCHS Fellow <input type="checkbox"/> CCHS Physician Assistant | \$ 80 |
| <input type="checkbox"/> CCHS Nurse Practitioner <input type="checkbox"/> CCHS Nurse | \$ 80 |
| <input type="checkbox"/> CCHS Other _____ | \$ 80 |

- I am a member of the Ohio Headache Association
 Confirmation Notice Preference: ___ US Mail ___ Fax ___ Email
 I request 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: _____ Last four (4) digits of SSN: _____
Mailing Address: _____ City/State/Zip: _____
Home Phone: _____ Business Phone: _____ Fax Number: _____
Email address _____ Specialty: _____

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