

## CCF & CCHS EMPLOYEE REGISTRATION FORM

**Course Number:** 020477  
**Course Name:** Heart Brain Summit 2008  
**Course Date:** June 4-5, 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, refreshment breaks and Reception/Dinner.*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> CCF Staff Physician   | <input type="checkbox"/> CCF Resident                 | <input type="checkbox"/> CCF Fellow         |
| <input type="checkbox"/> CCF Pharmacist  | <input type="checkbox"/> CCF Nurse                    | <input type="checkbox"/> CCF Other _____    |
| <input type="checkbox"/> CCHS Staff Physician  | <input type="checkbox"/> CCHS Resident                | <input type="checkbox"/> CCHS Fellow        |
| <input type="checkbox"/> CCHS Pharmacist   | <input type="checkbox"/> CCHS Nurse                   | <input type="checkbox"/> CCF Other _____    |
| <input type="checkbox"/> Full Registration - \$100.00  | PER DAY: <input type="checkbox"/> Wednesday - \$65.00 | <input type="checkbox"/> Thursday - \$65.00 |
| <input type="checkbox"/> I will attend Poster Session/Reception/Dinner on Wednesday, June 4 <sup>th</sup> .                  |   |   |
| <input type="checkbox"/> My Guest will attend Poster Session/Reception/Dinner on Wednesday, June 4 <sup>th</sup> . - \$65.00 |   |   |

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**