

# CCF EMPLOYEE REGISTRATION FORM

**Course Name:** Nephrology Update 2008/Cardio Renal Summit  
**Course Number:** 011543  
**Course Date:** October 4-7, 2008  
**Course Location:** Ritz Carlton Hotel \* 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, Anesthesia Department personnel at Huron, Hillcrest, Euclid, Marymount and Lutheran

**CCF Staff Physician: Full Course (Oct. 4-7) - \$400.00**

(includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**PER DAY FEES:** (includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**Days Attending:**  **Saturday only (Oct. 4) - Cardio Renal Summit - \$125.00**

**OR**  **Sunday-Tuesday (Oct. 5-7) - Nephrology Update - \$300.00**

I require vegetarian meals.

I will attend the Welcome Reception, Sunday, Oct. 5th

\$40.00 additional - I would like to purchase the CD ROM of the final presentations

**CCF Resident**

**CCF Fellow**

**CCF Nurse**

**CCF Other Employee** \_\_\_\_\_

(includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**Full Course (Oct. 4-7) - \$250.00**

**PER DAY FEES:** (includes syllabus, workshops, continental breakfasts, refreshment breaks, and reception)

**Days Attending:**  **Saturday only (Oct. 4) - Cardio Renal Summit - \$40.00**

**OR**  **Sunday-Tuesday (Oct. 5-7) - Nephrology Update - \$200.00**

I require vegetarian meals.

I will attend the Welcome Reception, Sunday, Oct. 5th

\$40.00 additional - I would like to purchase the CD ROM of the final presentations

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: \_\_\_\_\_ 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 SIGN-UP (Please indicate your choice)**

Sunday Workshop Choice

A or  B

Monday Workshop Choice

C or  D

Charge the following account:  **VISA**  **MASTERCARD**  **DISCOVER**  **AMERICAN EXPRESS**

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Total Amount to be Charged: \_\_\_\_\_

Signature: \_\_\_\_\_ (Not valid without signature)

CCF Cost Center Number \_\_\_\_\_ Signature \_\_\_\_\_  
Administrator

Credit card payment 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