

CLEVELAND CLINIC HEALTH SYSTEM REGISTRATION FORM

Course Number: 011561
Course Name: Obesity Summit 2008
Course Date: September 10-12, 2008
Location: InterContinental Hotel & Bank of America * 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 breakfasts, breaks, lunch and reception.

	<u>Full Course</u>	<u>Wednesday</u>	<u>Thursday/Friday</u>
<input type="checkbox"/> CCHS Physician	<input type="checkbox"/> \$400	<input type="checkbox"/> \$240	<input type="checkbox"/> \$240
<input type="checkbox"/> CCHS Fellow	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> CCHS Resident	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> CCHS Nurse	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> CCHS Nurse Practitioner	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> CCHS Physician Assistant	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> CCHS Dietitian	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> CCHS Other _____	<input type="checkbox"/> \$280	<input type="checkbox"/> \$140	<input type="checkbox"/> \$140
<input type="checkbox"/> Vegetarian meals requested.		<input type="checkbox"/> I will attend the reception.	

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: _____ Last four (4) digits of SSN: _____
 Mailing Address: _____ City/State/Zip: _____
 Home Phone: _____ Business Phone: _____ Fax Number: _____
 Email _____ Specialty: _____

Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____ 3 / 4 digit v-code _____
 Total Amount to be Charged: _____

Signature: _____ (Not valid without signature)

CCF Cost Center Number _____ Signature _____
Administrator

**Credit card 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**