CLEVELAND CLINIC HEALTH SYSTEM
EMPLOYEE REGISTRATION FORM

Course Number: **011525 - 10th Annual Pain Management Symposium**
Course Date: **February 16-20, 2008**
Location: **Loews Coronodo Bay Resort & Spa * Coronodo, CA**

Hospital Affiliation: Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, South Pointe
CCHS Affiliates: Grace Hospital, Ashtabula County Medical Center

	FULL REGISTRATION	**PER DAY**
	Registration includes syllabus, continental breakfasts, refreshment breaks, one lunch and Reception.	
☐ **CCHS Staff Physician (MD/PhD):**	**$600**	**$148**
☐ **CCHS CRNA**	**$500**	**$128**
☐ **CCHS Resident**	**$300**	**$ 88**
☐ **CCHS Fellow**	**$300**	**$ 88**
☐ **CCHS Physician Assistant**	**$300**	**$ 88**
☐ **CCHS S-RNA / Nurse**	**$300**	**$ 88**
☐ **CCHS Other_____**	**$300**	**$ 88**

☐ Full Attendance ***or*** ___Saturday ___Sunday ___Monday ___Tuesday ___Wednesday

☐ I will attend the Reception. Number of people attending_____.

☐ I will attend Monday Luncheon Presentation. ☐ I require a vegetarian meal.

☐ 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, PharmD, (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_____ Specialty_____

Problem Based Learning Discussion Sign-up (FREE)
6:00 – 7:00 pm **(Please select only one per day)**

Sunday	A____	B____	C____
Monday	D____	E____	F____
Tuesday	G____	H____	I____

Optional Cadaver Workshop Sign-up
Fee $500 per Workshop/Day (1:30 – 5:30 pm)
(Please indicate your choice)

II. Saturday_____ III. Sunday _____
IV.Monday _____ V. Tuesday_____

Optional Live Model Workshop Sign-up
Fee $200 (3:00 – 5:00 pm)
I. Saturday_____

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

Credit Card Number:_____ Expiration Date:_____ 3 digit v-code on the back of card)_____

Total Amount to be Charged:_____ Signature:_____ (Not valid without signature)

CCF Department Account Number _____ Signature _____
Administrator

Credit card or Dept. Charge payment may be expedited by completing and faxing this form to: (216) 445-9406 or
Mail check <u>and</u> registration form to: The Cleveland Clinic Foundation, P. O. Box 931653, Cleveland, OH 44193-1082