

CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: 020522
Course Name: Women's Sports Health Update: Fitness, Injury and Bone Health
Course Date: November 1, 2008
Location: Cleveland Clinic Administrative Campus, Bldg 3-LL-120, Beachwood, 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

CCHS Hospital Affiliation: Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, South Pointe

CCHS Affiliates: Grace Hospital, Ashtabula County Medical Center

Registration includes syllabus on CD, continental breakfast, breaks and lunch.

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|---|---|--------------------------------|
| <input type="checkbox"/> CCF Staff | <input type="checkbox"/> CCHS Physician | <input type="checkbox"/> \$156 |
| <input type="checkbox"/> CCF Resident | <input type="checkbox"/> CCF Fellow | <input type="checkbox"/> \$120 |
| <input type="checkbox"/> CCF Allied Health _____ | <input type="checkbox"/> CCF Nurse | <input type="checkbox"/> \$117 |
| <input type="checkbox"/> CCHS Resident | <input type="checkbox"/> CCHS Fellow | <input type="checkbox"/> \$120 |
| <input type="checkbox"/> CCHS Allied Health _____ | <input type="checkbox"/> CCHS Nurse | <input type="checkbox"/> \$117 |

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/CCHS Phone: _____ CCF/CCHS Fax: _____ Mail Code: _____

Mailing Address _____ City/State/ZIP: _____

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Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____ 3/4 digit v-code _____

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Administrator

Credit card or cost center 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