

**CLEVELAND CLINIC HEALTH SYSTEM  
EMPLOYEE REGISTRATION FORM**

**Course Number:** 011591  
**Course Name:** Biologic Therapies Summit III  
**Course Date:** May 7-9, 2009  
**Course Location:** InterContinental Hotel & Bank of America Conference Center \* Cleveland, OH

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

*Full and Per Day Registration includes syllabus, continental breakfasts, refreshment breaks, lunches, sessions and Gala Reception at the Cleveland Metroparks Zoo.*

	<u>FULL REGISTRATION</u>	<u>PER DAY</u>
<input type="checkbox"/> CCHS Staff Physician	\$ 225	\$ 92.50
<input type="checkbox"/> CCHS Resident	\$ 112.50	\$ 55
<input type="checkbox"/> CCHS Fellow	\$ 0	\$ 0
<input type="checkbox"/> CCHS Nurse	\$ 112.50	\$ 55
<input type="checkbox"/> CCHS Other _____	\$ 112.50	\$ 55

Full Attendance *or* Per Day: \_\_\_Thursday \_\_\_Friday \_\_\_Saturday

I request vegetarian meals.

I will attend the Gala Reception on Thursday at 7:00pm

I will require an extra ticket for a guest for the Gala Reception at \$50 per ticket. \_\_\_ # of tickets

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: \_\_\_\_\_ Email Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please check the following Saturday breakout session you plan to attend:

- Rheumatology       Allied Health       Gastroenterology

Charge the following account:     VISA     MASTERCARD     AMERICAN EXPRESS     DISCOVER

3/4-digit verification code on back of card \_\_\_\_\_      Total Amount Enclosed \$ \_\_\_\_\_

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

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

Charge the following CCHS Dept cost center \_\_\_\_\_

Signature \_\_\_\_\_  
(Administrator)

**Fax number: (216) 445-9406 OR**

**Mail check and registration form to:** The Cleveland Clinic Foundation, P.O.Box 931653, Cleveland, OH 44193-1082