

CCF EMPLOYEE REGISTRATION FORM

Course Name: 12th Diastology and New Echo Technologies Summit
Course Number: 011595
Course Date: February 4-7, 2009
Location: Hyatt Regency Bonaventure - Ft. Lauderdale, FL

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** (includes syllabus, continental breakfasts, breaks, and reception)
- \$200 Full Registration
 - \$85 Per Day
 - Wednesday Thursday Friday Saturday
 - I will attend the reception on Friday.
- CCF Resident** **CCF Fellow** **CCF Nurse** **CCF Sonographer** **CCF Other** _____
- (includes syllabus, continental breakfasts, breaks, and reception)
- \$175 Full Registration
 - \$79 Per Day
 - Wednesday Thursday Friday Saturday
 - I will attend the reception on Friday.

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: _____ Mail Code: _____

CCF Phone: _____ CCF Fax: _____ Home Phone Number: _____

Mailing Address _____ City/State/ZIP _____

Specialty: _____ Email: _____

Evening Workshops (concurrent)

- Thursday Workshop A or Thursday Workshop B
 Friday Workshop A or Friday Workshop B

Charge the following credit card: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____ 3/4digit code on back of card _____

Total Charge: _____

Signature: _____ Date: _____

(not valid without signature)

Charge the following CCF Dept Cost Center: _____

Signature _____
Administrator

Credit card or Dept. 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