

**CLEVELAND CLINIC HEALTH SYSTEM
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

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

<input type="checkbox"/> CCHS Physician (includes syllabus, continental breakfasts, breaks, and reception) <input type="checkbox"/> \$540 Full Registration <input type="checkbox"/> \$163 Per Day <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> I will attend the reception on Friday. <input type="checkbox"/> CCHS Resident <input type="checkbox"/> CCHS Fellow <input type="checkbox"/> CCHS Nurse <input type="checkbox"/> CCHS Sonographer <input type="checkbox"/> CCHS Other _____ (includes syllabus, continental breakfasts, breaks, and reception) <input type="checkbox"/> \$300 Full Registration <input type="checkbox"/> \$103 Per Day <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> I will attend the reception on Friday.
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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: _____
Specialty _____ Email _____

Evening Workshops (concurrent) <input type="checkbox"/> Thursday Workshop A or <input type="checkbox"/> Thursday Workshop B <input type="checkbox"/> Friday Workshop A or <input type="checkbox"/> Friday Workshop B

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

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

Total Amount to be Charged: _____

Signature: _____ (Not valid without signature)

Charge the following CCHS Dept Cost Center: _____

Signature _____
Administrator

Credit card payment 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