

CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: 011607
Course Name: Advances in Gynecologic Surgery
Course Date: May 13-16, 2009
Location: InterContinental Hotel & Bank of America Conference Center

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

Fee includes attendance, syllabus, lunch, and refreshment break.

Full Course \$500.00

CCF Staff
 CCF Nurse

CCF Resident
 CCF Non-Physician

CCF Fellow

CCHS Physician
 CCHS Nurse

CCHS Resident
 CCHS Non-Physician

CCHS Fellow

Per Day \$180.00 Wednesday Thursday Friday Saturday

CCF/CCHS Physician CCF/CCHS Resident CCF/CCHS Fellow CCF/CCHS Nurse CCF/CCHS Non-Physician

I will attend the Conference Reception on Thursday, May 14, 2009

I will NOT attend the Conference Reception on Thursday, May 14, 2009

I require vegetarian meals.

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: _____ Home Phone Number: _____

Email: _____

Charge the following account: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: _____

Total Amount to be Charged: _____

Signature: _____

3/4 digit v-code _____

(Not valid without signature)

(located on back of card)

CCF/CCHS Cost Center Number _____ Signature _____

Administrator

Credit card 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