CCF EMPLOYEE REGISTRATION FORM

Course Number: **011601**
Course Name: **Orthopaedic Rheumatology Care Quality Innovations Summit**
Course Date: **May 13-15, 2009**
Location: **InterContinental Hotel & Bank of America Conference Center * Cleveland, OH**

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 and Anesthesia Department personnel at Huron, Hillcrest, Euclid, Marymount and Lutheran

Registration fee includes syllabus, continental breakfasts, breaks, lunches, Poster Reception and Summit Banquet.

☐ **CCF Staff Physician**

☐ **Full Registration - $400.00** ☐ **Wednesday - $168.00** ☐ **Thursday - $168.00** ☐ **Friday - $168.00**

☐ **CCF Resident** ☐ **CCF Fellow**

☐ **CCF Nurse** ☐ **CCF Other Employee**____________________

☐ **Full Registration - $250.00** ☐ **Wednesday - $118.00** ☐ **Thursday - $118.00** ☐ **Friday - $118.00**

☐ **Vegetarian meals requested.**

☐ **I will attend the Wednesday Poster Reception.**

☐ **I will attend the Thursday Summit Reception**

☐ **My guest(s) will attend the Thursday Summit Reception_____# of tickets at $50.00 each**

☐ 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 Phone:_________________ CCF 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:______ 3 / 4 digit v-code_____

Total Amount to be Charged:______________

Signature:____ (Not valid without signature)

CCF Cost Center Number ____________________________ Signature ______________________________
Administrator

Credit card 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