

# CLEVELAND CLINIC HEALTH SYSTEM 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

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

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

**CCHS Staff Physician**

Full Registration - \$600.00     Wednesday - \$228.00     Thursday - \$228.00     Friday - \$228.00

**CCHS Resident**

**CCHS Fellow**

**CCHS Nurse**

**CCHS Other Employee** \_\_\_\_\_

Full Registration - \$380.00     Wednesday - \$155.00     Thursday - \$155.00     Friday - \$155.00

**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: \_\_\_\_\_ Last four (4) digits of SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

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

Email \_\_\_\_\_ Specialty: \_\_\_\_\_

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)

CCHS 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**