CCF EMPLOYEE REGISTRATION FORM

Course Number: **011591**
Course Name: **Biologic Therapies Summit III**
Course Date: **May 7-9, 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, Naples and Anesthesia Department personnel at Huron, Hillcrest, Euclid, Marymount and Lutheran

No Charge (full attendance or per day) – Registration includes continental breakfasts, refreshment breaks, lunches, sessions, and Gala Reception at the Cleveland Metroparks Zoo.

☐ **CCF Staff Physician** ☐ **CCF Resident** ☐ **CCF Fellow**
☐ **CCF Nurse** ☐ **CCF Other**___________________________

☐ Full Attendance ***or*** ___Thursday ___Friday ___Saturday

☐ I request vegetarian meals. ☐ I will attend the Gala Reception on Thursday at 7:00pm

☐ My Guest(s) will attend the Gala Reception - $50/ticket _____ # of tickets

☐ 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:____Email Address__________________________

City/State/ZIP:____ Home Phone Number: ___________________

Please check the following Saturday breakout session you plan to attend:

☐ Rheumatology ☐ Allied Health ☐ Gastroenterology

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

Credit Card Number:____________________________________ Expiration Date:___________________

3/4-digit verification # located on back of card______ Total Amount to be Charged:______________

Signature:____ (Not valid without signature)

Credit card payment may be expedited by completing and faxing this form to: (216) 445-9406
Mail check and registration form to: The Cleveland Clinic Foundation, P. O. Box 931653, Cleveland, OH 44193-1082