

# CCF EMPLOYEE REGISTRATION FORM

**Course Number:** 011597  
**Course Name:** Palliative Medicine & Supportive Oncology 2009  
**Course Date:** March 5-7, 2009  
**Location:** Hyatt Regency Bonaventure, Fort Lauderdale, FL

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

<input type="checkbox"/> <b>CCF Staff Physician</b> <input type="checkbox"/> <b>Full Registration - No Charge</b> (syllabus, continental breakfasts, breaks and reception)
<input type="checkbox"/> <b>CCF Resident</b> <input type="checkbox"/> <b>CCF Fellow</b> <input type="checkbox"/> <b>CCF Nurse</b> <input type="checkbox"/> <b>CCF Social Worker</b>
<input type="checkbox"/> <b>CCF Pharmacist</b> <input type="checkbox"/> <b>CCF Student</b> <input type="checkbox"/> <b>CCF Other Employee</b> _____
<input type="checkbox"/> <b>Full Registration - \$95.00</b> (syllabus, continental breakfasts, breaks and reception)
<input type="checkbox"/> I will attend the Symposium Reception. Number Attending: _____
<input type="checkbox"/> I will not attend the Symposium Reception.

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 \_\_\_\_\_

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CCF Cost Center Number \_\_\_\_\_ 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**