

# CCF & CCHS EMPLOYEE REGISTRATION FORM

**Course Number:** 0115401  
**Course Name:** ABIM Maintenance of Certification Learning Session  
**Course Date:** June 7, 2008  
**Location:** Lerner Research Institute, Cleveland Clinic, 5<sup>th</sup> Floor Amphitheater \* Cleveland, OH

**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

**Hospital Affiliation:** Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, South Pointe

**CCHS Affiliates:** Grace Hospital, Ashtabula County Medical Center

*Registration includes "Learner's Copy" of the ABIM Update in Hospital-Based & Office-Based Internal Medicine Modules, continental breakfast and refreshment break*

## FEES:

- \$ 25.00 Intensive Review of Internal Medicine Course ABIM certified Attendee
- \$ 125.00 Physician (not attending Intensive Review of Internal Medicine Course)
- \$ 75.00 Cleveland Clinic Physician
- \$ 75.00 Cleveland Clinic Health System Physician

Check here if you have any special needs that require additional assistance. A CME staff member will contact you to discuss your special requirements.

*CCF and CCHS Pharmacists who are registering for this course and would like to receive Ohio Pharmacy Credit for their attendance need to contact the CCF Pharmacy Department, Morton P. Goldman, PharmD, at (216) 444-1127 to have this course considered for Pharmacy credit at least 10 days prior to the course date.*

## 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: \_\_\_\_\_

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)

**Charge CCF Cost Center Account** \_\_\_\_\_ Signature \_\_\_\_\_  
Administrator

**Credit Card or Cost Center Account 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**