

# CCF & CCHS EMPLOYEE REGISTRATION FORM

**Course Number:** 011581  
**Course Name:** Congenital Heart Disease in the Adult  
**Course Date:** November 14, 2008  
**Location:** The InterContinental Hotel and Bank of America Conference Center, 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

**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 breakfast, refreshment breaks, and lunch and reception..*

**Registration Fee**

- |                                                                                                                                                                      |           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| <input type="checkbox"/> CCF/CCHS Staff Physician                                                                                                                    | \$ 100.00 |
| <input type="checkbox"/> CCF/CCHS Resident <input type="checkbox"/> CCF/CCHS Fellow <input type="checkbox"/> CCF/CCHS Nurse <input type="checkbox"/> CCF/ CCHS Other | \$ 40.00  |

\_\_\_ I will attend Welcome Reception at 6:15pm

\_\_\_ I require vegetarian meals.

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/CCHS Phone: \_\_\_\_\_ CCF/CCHS FAX: \_\_\_\_\_ Mail Code: \_\_\_\_\_

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

Home Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Charge the following account:     VISA     MASTERCARD     DISCOVER     AMERICAN EXPRESS

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

3/4 digit v-code located on back of card \_\_\_\_\_ Total Amount to be Charged: \_\_\_\_\_

Signature: \_\_\_\_\_ (Not valid without signature)

Charge the following CCF/CCHS cost center number: \_\_\_\_\_

Signature \_\_\_\_\_ (Administrator)

**Credit card or cost center number 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**