CCF & CCHS EMPLOYEE REGISTRATION FORM

Course Number: **020500**
Course Name: **3rd Annual Post Traumatic Stress Disorder Symposium**
Course Date: **November 21, 2008**
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 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 includes syllabus, continental breakfasts, lunches and refreshment breaks

☐ CCF Staff Physician	☐ CCHS Physician	☐ $100.00
☐ CCF Nurse ☐ CCF Resident ☐ CCHS Resident ☐ CCF Physician Assistant ☐ CCF Other____________	☐ CCHS Nurse ☐ CCF Fellow ☐ CCHS Fellow ☐ CCHS Physician Assistant ☐ CCHS Other____________	☐ $75.00
☐ CCF Student	☐ CCHS Student	☐ $75.00

☐ 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______________________________

Charge the following credit card: ☐**VISA** ☐**MASTERCARD** ☐**DISCOVER** ☐**AMERICAN EXPRESS**

Credit Card Number:______________ Expiration Date:_____ 3/4 digit code on back of card____

Total Charge:__________

Signature:______________________________ Date:______________

(not valid without signature)

Charge the following CCF/CCHS cost center account: ______________________________

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