Cleveland Clinic and Cleveland Clinic Health Systems
EMPLOYEE REGISTRATION FORM

Course Number: **020542**
Course Name: **3rd Annual International Symposium on Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery**
Course Date: **February 20-22, 2008**
Location: **Disney's Grand Floridian Resort & Spa * Lake Buena Vista, FL**

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 Affiliates**:** Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, South Pointe
CCHS Affiliates**:** Grace Hospital, Ashtabula County Medical Center

Complimentary registration (includes syllabus, continental breakfasts, welcome reception and 1 ticket to WALT DISNEY WORLD RESORT reception).

☐ CCF/CCHS Staff Physician ☐ CCF/CCHS Physicist
☐ CCF/CCHS Nurse ☐ CCF/CCHS PhD ☐ CCF/CCHS Resident ☐ CCF/CCHS Fellow
☐ CCF/CCHS Allied Health

☐ I will attend the Welcome Reception (no charge)
___ # of Guest(s) - Additional ticket(s) for Reception

☐ I will attend the WALT DISNEY WORLD RESORT Reception
___ Additional ticket(s) for Saturday Reception - $40 per person age 10 and up
___ Additional ticket(s) for Saturday Reception - $15 per child age 9 and under

☐ 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 CODE ________________

Home Phone Number::________________________ 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)

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