

# Registration Form

|                                 |               |
|---------------------------------|---------------|
| Course 011991   Office Use Only |               |
| Fee _____                       | Date _____    |
| MOP _____                       | CXL/Fee _____ |

6th Annual

## Advanced Management Issues in HIV Medicine *Focus on Hepatitis C Virus*

**May 30 – 31, 2013**

InterContinental Hotel and Bank of America Conference Center | Cleveland, OH

### Register Online

**ccfcme.org/1HIV13**

Once you register online, please do not mail in a registration form. **Cleveland Clinic and Cleveland Clinic Health System employee fees and registration are available online only.**

### Fees

|                                                                                                                                                             |           |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------------------------------------|
| Fee includes electronic syllabus, continental breakfast, lunch, refreshment breaks, and dinner. Payment must be recieved prior to admittance to the course. |           | <b>Breakout Session Sign Up<br/>10:30 am – 11:30 am</b>                                           |
| <input type="checkbox"/> Physician                                                                                                                          | \$150     |                                                                                                   |
| <input type="checkbox"/> Resident/Fellow*                                                                                                                   | No Charge | <input type="checkbox"/> A. HCV Case Studies                                                      |
| <input type="checkbox"/> Nurse/Nonphysician                                                                                                                 | \$75      | <input type="checkbox"/> B. Pain Management                                                       |
| <input type="checkbox"/> Allied Health Professional/Other                                                                                                   | \$75      | <input type="checkbox"/> C. Case Studies:<br>Newer Medications                                    |
| *Letter from program director must be received in our office prior to the course to receive this fee. Non-compliance results in full physician fee.         |           | <input type="checkbox"/> I will attend the Dinner on<br><b>THURSDAY, MAY 30, 2013<br/>6:30 pm</b> |
|                                                                                                                                                             |           | <input type="checkbox"/> I require vegetarian meals.                                              |

### Please Print

Complete the information below if registering by mail.

|                   |                                       |                                         |                                                                         |
|-------------------|---------------------------------------|-----------------------------------------|-------------------------------------------------------------------------|
| First Name:       | MI:                                   | Last Name:                              | Degree:                                                                 |
| <hr/>             |                                       |                                         |                                                                         |
| Institution Name: |                                       |                                         |                                                                         |
| <hr/>             |                                       |                                         |                                                                         |
| Address:          |                                       |                                         |                                                                         |
| <hr/>             |                                       |                                         |                                                                         |
| City:             | State:                                | Zip:                                    |                                                                         |
| <hr/>             |                                       |                                         |                                                                         |
| Phone Number:     | Fax Number:                           |                                         |                                                                         |
| <hr/>             |                                       |                                         |                                                                         |
| Email Address:    | Specialty:                            |                                         |                                                                         |
| <hr/>             |                                       |                                         |                                                                         |
| Practice Type:    | <input type="checkbox"/> Office-Based | <input type="checkbox"/> Hospital Staff | <input type="checkbox"/> Resident/Fellow <input type="checkbox"/> Other |
| <hr/>             |                                       |                                         |                                                                         |

**Total amount enclosed: \$ \_\_\_\_\_**

**Make check payable: The Cleveland Clinic Educational Foundation**

**Mailing address:** The Cleveland Clinic Educational Foundation  
PO Box 931653, Cleveland, OH 44193-1082

**For registration questions, please email [cmeregistration@ccf.org](mailto:cmeregistration@ccf.org) or call 216.448.0777**

Cleveland Clinic recognizes the importance of protecting the privacy and security of information provided to us. Therefore, we are no longer requesting credit card data in writing, including on registration forms or faxes. If you would like to register using a credit card, please log in to [www.ccfcme.org/1HIV13](http://www.ccfcme.org/1HIV13) or call 216.448.0777 where it will be handled directly by a certified processor.