

REGISTRATION FORM

PROFESSIONAL DEVELOPMENT COURSES

SUMMER 2009

Please PRINT OR TYPE CLEARLY and return form and payment to:

Lea Alae, Program Coordinator
 lea.alae@cchmc.org Fax (513) 636-7247 Phone (513) 636-4183
 Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, MLC 2011, Cincinnati, OH 45229

Last name _____ First name _____ Middle initial _____
 Permanent Street Address _____ City _____ State _____ Zip _____
 Email _____ Telephone Number Cell Home Work _____
 Highest degree attained _____ College or University _____ Date of Graduation (mm/yy) _____

Are you currently a graduate student or matriculated into a graduate program at the University of Cincinnati?

YES – UCID: M _____ Program _____

NO – please complete the following information:

County of Residence (if in Ohio) _____ Date of Birth (mm/dd/yy) _____ Country of Citizenship _____
 High School attended _____ State _____ Year of Graduation _____
 Have you ever attended or applied to the University of Cincinnati? _____ If yes, when? _____
 Current Employer _____ When employed? _____
 Marital Status Married Single Ethnicity (optional): American Indian or Alaskan Native Asian or Pacific Islander
 Black, Non-Hispanic White, Non-Hispanic Hispanic Other

I attest that the above information is complete and true.

Signature _____ Date _____

REGISTRATION FOR:	Register?	Course #	Course Name	Reg. Cost	UC Faculty/Staff *
	<input type="checkbox"/>	18 CI 780P	Simulation: An Educational Strategy	<input type="checkbox"/> \$500.00	<input type="checkbox"/> \$248.00 *
	<input type="checkbox"/>	18 CI 781P	Academic Writing	<input type="checkbox"/> \$750.00	<input type="checkbox"/> \$372.00 *

*A student with UC Tuition Remission is responsible for filing the appropriate forms with UC HR prior to the quarter start. If the forms are not completed, and Tuition remission is not applied, the student WILL BE billed an **additional \$206/credit hour** directly by and payable to UC.

PAYMENT METHOD: Check/Money Order # _____ (Make payable to **Cincinnati Children's Hospital Medical Center**)
 Credit Card Visa Mastercard Discover AMEX
 Account # _____ Exp. Date _____
 Name on Card _____
 Cardholder Signature _____