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FCPA

Florida Ceft Palate-Craniofacial Association, Inc.
P.O. Box 6006
Brandon, Florida 33508
E-mail: secretary@floridacleft.org ; Website: http://www.floridacleft.org

2010 Membership Application

Name: _____
First Middle Last

Check one: ___Dr. ___Mr. ___Mrs. ___Ms. ___Other (specify) _____

Mailing address: _____
Number, Street, Suite, Apt., etc.

_____
City, State, ZIP

Telephones: (Home) (____) _____ (Office) (____) _____ (FAX) (____) _____
(Home numbers are not published)

E-mail: _____ **WWW Web site:** _____
(Important for notifications, will ***not*** be published)

Area(s) of specialization (please check any that apply):

Dentistry:
___ General Dentistry
___ Oral Surgery
___ Orthodontics
___ Pediatric Dentistry
___ Prosthodontics
___ Other Dentistry (specify) _____

Medicine:
___ Otolaryngology
___ Pediatrics
___ Plastic/Reconstructive Surgery
___ Other Medicine (specify) _____

___ Audiology
___ Genetics
___ Nursing
___ Research
___ Parent
___ Social Work
___ Speech/Language Pathology
___ Student

___ **Other Profession** (specify) _____

Education: Institution and Location: _____

Degree(s) & Date(s) conferred: _____

Certifications and Licenses (relevant to Association concerns):

_____
Issuing Organization, Date and Title or Name of Certificate/License (use reverse side or attach *curriculum vita* for additional listings).

Geographic Location of Practice: _____

Signature: _____ **Date:** _____

Note: This application should be completed and submitted to the chairperson of the membership committee at the above association address. Include a check for payment of the first year's dues (check made payable to the Florida Cleft Palate-Craniofacial Association, Inc.). Membership runs from January 1st through December 31, 2010, Professional dues: $120; Parent Dues: $75; Full-time student: free, with recommendation from department head.

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