



FCPA

Florida Cleft Palate-Craniofacial Association, Inc.

2010 50th Annual Symposium Registration Form

August 27th-28th, 2010

Make checks payable to **Florida Cleft Palate - Craniofacial Association** (info@floridacleft.org) and mail with this registration form to: FCPA Secretary, P.O. Box 6006, Brandon, FL 33508, FAX: 813-655-6537

Sorry, we do not accept credit card payments. We will accommodate Government and institutions by providing a pro-forma invoice, if required.

NAME: _____

Specialty: _____

Street: _____

City: _____ ST: _____ ZIP: _____

Business Phone: _____ FAX: _____

Email-address PLEASE: _____ (Required for receipts, acknowledgements and future meetings advances. We DO NOT sell or distribute your email address. Only FCPA members may request email addresses)

**FOR NON-MEMBER PROFESSIONALS (ATTENDING the symposium):
Or former FCPA Members who have not paid 2010 Dues by March 31, 2010**

\$ _____ Symposium Registration Fee: **\$190.00** (Includes luncheon for one & complimentary membership until December 31, 2010)

We only accept CASH or CHECK on the day of the conference.

Sorry no Purchase order numbers at the door

\$ _____ Extra Sat. Luncheon(s): **\$20** per person as your guest

\$ _____ Registration fee for Nurses Pre-Symposium Conference: \$50

\$ _____ Registration fee for Speech Pre-Symposium Conference: \$50

\$ _____ **Total Enclosed**

Please include a Membership Application to be submitted with this registration. Even if you are a previous FCPA member, this will insure our record of your contact information is current.

Symposium will be at **The Naples Grande Resort, 475 Seagate Drive, Naples, Florida 34103,**
(888) 422-6177, www.naplesgranderesort.com

**Enjoy world class swimming pools, slides and a beautiful private beach. Incredible Room Rate:
\$115 /night, available 3 days prior to and after the symposium.**

Rooms are subject to availability, so book as early as possible!

*****We accept CASH or CHECK only for Symposium Registration on the day of the conference.*****

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Florida Cleft 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.