Florida Cleft Palate-Craniofacial Association, Inc.

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

2009 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, 2009, Professional dues: $100; Parent Dues: $75; Full-time student: free, with recommendation from department head.

Listed as a 501(c)(3) non-profit organization by the U.S. Internal Revenue Service (EIN 59-2038435)
Exempt from Florida Sales Tax - Certificate # 85-8012613394C-4