FCPA

Florida Cleft Palate-Craniofacial Association, Inc.
6300 Sagewood Drive Park City, UT 84098
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2017 Membership Application

Name_____
First Middle Last

Check One: Dr. Mr. Mrs. Ms. Other (Specify):_____

Mailing Address:_____
Number, Street, Suite, Apt., Etc.

Telephone: Personal_____Office_____Fax_____

Email:_____Web Site:_____

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

	Dentistry		Medicine		Other:_____		Other:_____
	General Dentistry		Pediatrics		Under Graduate		Nursing
	Oral Surgery		Plastic/Reconstructive Surgery		Post Grad/Fellow/ Resident		Speech/Language Pathology
	Pediatric Dentistry		Other:_____		Audiology		Research
	Prosthodontics				Genetics		Social Work
	Other:_____				Other:_____		Other:_____

Education: Institution and Location:_____

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

Certificate and Licenses (relevant to Association Concerns):

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

Geographic Location and 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 1 through December 31, 2017, Professional dues $135; Full-Time post-graduate student/fellow/CFY/Resident: $35.00, with recommendation from the department head; Full time under-graduate: free, with recommendation from department head. Parent membership: $75