



# Invitation to join CleftPALS

We wish to apply for our membership with CleftPALS. Please note memberships due 31 May annually.

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First Name	Surname
Father's Name _____	_____
Mother's Name _____	_____
Baby's Name _____	_____
Date of birth _____	Sex _____
Address _____	_____
_____	Post Code _____
Telephone No. _____	Mobile _____
Email Address _____	_____
Nationality/Languages (optional) _____	

Cleft Type		Lip	Gum	Hard Palate	Soft Palate
Unilateral	Complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Incomplete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilateral	Complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Incomplete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Syndromes eg. Pierre Robin Sequence					

How was baby fed in hospital? \_\_\_\_\_

Hospital born at \_\_\_\_\_

Hospital for surgery \_\_\_\_\_ Surgeon \_\_\_\_\_

Approximate dates for surgery \_\_\_\_\_

Contact Parents \_\_\_\_\_ Phone No. \_\_\_\_\_

We enclose	<input type="checkbox"/>	Cheque	<input type="checkbox"/>	Money Order	<input type="checkbox"/>	Cash
Being for	<input type="checkbox"/>	\$30.00 Standard Membership				
	<input type="checkbox"/>	\$20.00 Pensioner / Student / Special Membership				
	<input type="checkbox"/>	\$ _____ Donation. Do you require a receipt?				YES / NO

**THE CLEFT LIP AND PALATE SOCIETY NSW Inc**