POURQUOI PAS?
INTERNATIONAL SOCIETY OF CRANIO FACIAL SURGERY
THE CRANIO FACIAL CHAPTER OF THE INTERNATIONAL CONFEDERATION
IPRAS

CRANIOFACIAL ORTHODONTIC MEMBER APPLICATION

INSTRUCTIONS : PLEASE TYPE OR PRINT ALL INFORMATION

NAME (surname first) _____

MAILING ADDRESS _____

_____

_____

TELEPHONE _____ FACSIMILE _____

E-MAIL ADDRESS _____

SIGNATURE _____ DATE OF APPLICATION _____

Enclosed with this application:

1. A list of documented orthognathic and craniofacial cases (operative reports, team notes, treatment records, etc.) which you have treated in the 24 months immediately preceding the date of this application (see attached Appendix from By-Laws).

2. A list of craniofacial and/or cleft lip and palate team members stating their names and specialty.

3. A list of publications and scientific contributions including full curriculum vitae.

4. Letters of sponsorship from two current members of this Society : one Active Member and one Craniofacial Orthodontic Member (may be sent separately).

5. A letter from the head of the program where you trained in craniofacial orthodontics for at least six months. If not applicable, please explain.

6. A non-refundable processing fee of USD $50.00 payable to the International Society of Craniofacial Surgery. Please use the Processing Fee Payment Form (can be downloaded in Application Section).

7. A completed Active Craniofacial Orthodontist Certification (please see next page *or* can be downloaded in Application Section).

IMPORTANT : NO APPLICATION WILL BE ACCEPTED UNLESS ALL OF THE ABOVE ARE ASSEMBLED TOGETHER IN A SINGLE PACKAGE (except number 4).

CRANIOFACIAL ORTHODONTIC MEMBER CERTIFICATION

By my signature on this form, I hereby certify that all information submitted within this application is accurate and complete.

I certify that I am a legally qualified practicing orthodontist, active in craniofacial/cleft orthodontics.

I have been in active practice of craniofacial/cleft orthodontics for at least five (5) years.

I am an active member of the official Orthodontic Society of my country and practice this specialty in my country.

Date of certification : _____

APPLICANT'S SIGNATURE : _____

SEND YOUR COMPLETE APPLICATION PACKAGE TO :

Dr. Eric Arnaud
ISCFS Secretary-Treasurer
130 Rue de la Pompe
75116 PARIS, France
Tel: +(33)-1 47 27 44 31
Fax: +(33)-1 47 27 65 15