CORRESPONDING MEMBER APPLICATION

INSTRUCTIONS: ***PLEASE TYPE OR PRINT ALL INFORMATION***

NAME (surname first) _____

MAILING ADDRESS _____

_____

_____

TELEPHONE NUMBER _____ FAX _____

E-MAIL ADDRESS _____

S

IGNATURE _____ DATE OF APPLICATION _____

Enclosed with this application:

1. A list of craniofacial clinical team members stating their names and specialty.
2. A list of publications and scientific contributions including full curriculum vitae.
3. Letters of sponsorship from two presently active members of this Society (may be sent separately).
4. A letter from the head of your craniofacial program.
5. A processing fee of USD $50.00 payable to the International Society of Craniofacial Surgery. Please use the Processing Fee Registration Form (can be downloaded in Application Section).
6. **NO APPLICATION WILL BE ACCEPTED UNLESS ALL OF THE ABOVE ARE ASSEMBLED TOGETHER IN A SINGLE PACKAGE** (except number 3).

Send your application package to:

Docteur Eric Arnaud
Secretary -Treasurer, ISCFS
130 Rue de la Pompe
75116 PARIS, France
Tel: +(33)-1 47 27 44 31 - Fax: +(33)-1 4727 65 15

CORRESPONDING MEMBER
CERTIFICATION

By my signature of this form, I certify that I am a qualified member of a team active in craniofacial surgery.

I am an active member of a major medical specialty society and practice this specialty in my country.

DATE OF CERTIFICATION: _____

APPLICANT'S SIGNATURE: _____
(Corresponding Membership)