



Send complete form & payment to:
 CleftPALS Australia
 National Treasurer
 PO Box 475
 Lane Cove NSW

CleftPALS Membership Form

We wish to APPLY / RENEW our membership with CleftPALS.

(Strike through whichever is not applicable)

	Given Name(s)	Surname
Father / Guardian:	_____	_____
Mother / Guardian:	_____	_____
Child:	_____	_____
Date of birth:	_____	Sex: M / F
Postal address:	_____	Postcode: _____
Email:	_____	Phone (work): _____
Phone (home):	_____	
Mobile:	_____	

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 (eg. Syndromes - Pierre Robin Sequence):					

CleftPALS Volunteer: _____

(i.e. Who from CleftPALS first visited you in hospital or contacted you?)

How was your baby fed in hospital? _____

Born at: _____

Surgeon: _____

Hospital for surgery: _____

Dates for surgery: _____

We enclose: Cheque / Money Order - payable to 'CleftPALS Australia'

Being for: \$30 standard membership

\$20 Pensioner / Student / Health Care Card

Donation I require a receipt for my donation

How did you hear about CleftPALS?
