INVITATION
to join CleftPALS NSW

CleftPALS NEW SOUTH WALES Inc.
the sharing helps

We wish to apply for our membership to CleftPALS NSW.

CONTACT INFORMATION						
	Title	**First Name**	**Surname**			
Parent / Carer 1						
Parent / Carer 2						
Child's Name			**Sex**		**Date of Birth**	/ /
Email						
Postal Address						
State		Post Code		**Home Phone Number**		
Mobile Number	**Parent / Carer 1**		**Parent / Carer 2**			
Nationality / Language Spoken (optional)						

CLEFT TYPE (tick type)		Lip	Gum	Hard Palate	Soft Palate
Unilateral	**Complete**	☐	☐	☐	☐
	Incomplete	☐	☐	☐	☐
Bilateral	**Complete**	☐	☐	☐	☐
	Incomplete	☐	☐	☐	☐
Other (e.g. Syndromes – Pierre Robin Sequence)					

HOSPITAL INFORMATION / TREATMENT (optional)	
Which hospital was your baby born at?	
How was your baby fed in hospital?	
Which hospital was surgery performed?	
Who was the surgeon?	
Approximate dates of surgery?	

PAYMENT DETAILS		
Membership	☐ $30 for lifetime membership	
Payment Type	☐ Electronic Funds Transfer	
Membership Bank Account Details	**Bank Details:**	**Westpac** BSB: 032 349 Account Number: 231 107 Reference: Enter Your Surname
Payment Date	/ /	

Would you like to help volunteer for CleftPALS NSW?	☐ Yes ☐ No			
Additional Notes				
Office Use Only	Processed By		Date	/ /

CLEFT PALATE & LIP SOCIETY NSW INC.

membership@cleftpals ◆ PO Box 475, Lane Cove NSW 1595 ◆ 02 9294 8944
www.cleftpalsnsw.org.au ◆ All donations ove $2 are tax deductible

A.B.N. 24 130 036 620