



## 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: \_\_\_\_\_

*Once completed, please send your application file to:*

**Prof. Dr. Irene Mathijssen**  
**ISCFS Secretariat**  
**Eendrachtsweg 57b**  
**3012 LE Rotterdam**  
**The Netherlands**  
**Phone : +(31)-10-7036393**  
**Fax : +(31)-10-7036844**  
**e-mail : [info@iscfs.org](mailto:info@iscfs.org)**