Cleft Project Application Form

1. Please enclose photographs in the boxes as required

Please enclose a photograph of Surgeon	Please enclose a photograph of the hospital

2. Name of Partner

Name of the Surgeon	Name of the Hospital	Proposed Project Location

3. Details of the Surgeon

Qualification	
Year of Qualification	
Registration valid until	
Age	
Marital Status	
Living in the proposed location since	
Professional activities	
Consultant at	
Teaching	
Private clinic	
Affiliation with other cleft organizations: (past and present)	
Professional activities	
Consultant at	
Teaching	
Private clinic	
Affiliation with other cleft organizations (past and present)	
Fellowship or Training in CLP surgery	
Further interests	
Reason for opening a cleft project	

4. Name of the hospital

No. of Beds	
Specialities Covered	
Facilities for CLP surgery	
OT	
Wards	
Social Outreach	
Type of legal Entity	

5. CLP patients

Geographical areas to be covered:	
Number of patients treated privately or under any other charity:	
Number of patients expected in first 3 months:	
Number of patients expected in one year (12 months):	

6. Comprehensive care

Will orthodontics and speech therapy be integrated in the project?	Interested in Orthognathic surgery, only CLP related?

Date of application: ☐☐ ☐☐ ☐☐☐☐
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Name: Signature

FOR OFFICE USE ONLY

DATE WHEN FIRST APPLIED	RESPONSIBLE PERSON	REFERENCE