



**AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS**  
**VERIFICATION OF MEMBERSHIP IN COMPONENT COUNTRY OMS SOCIETY**



Name of Candidate for AAOMS Membership \_\_\_\_\_

Degree(s) \_\_\_\_\_

***Effective September 27, 1991 -- All Candidates for AAOMS membership must be members of their country OMS society in which their primary practice is located to be eligible for election to AAOMS membership.***

Are you a member of your country OMS society?     Yes     No

If you are not a member, have you applied for membership?     Yes     No

**PRIMARY OFFICE ADDRESS**

Suite/Floor \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

Postal Code \_\_\_\_\_

Country \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Primary E-mail Address \_\_\_\_\_

**HOME ADDRESS**

Apartment \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

Postal Code \_\_\_\_\_

Country \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Primary E-mail Address \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY COUNTRY OMS SOCIETY:**

This is to certify that the above-named candidate for membership in the American Association of Oral and Maxillofacial Surgeons is in one of the following categories in the country OMS society:

Current Status in Country Society:     Fellow     Member     Resident     Candidate     Provisional

If missing components to complete membership, please specify (example: specialty license, anesthesia evaluation, etc.) \_\_\_\_\_

Name of OMS Society \_\_\_\_\_

Address \_\_\_\_\_

Name of Officer/Administrator \_\_\_\_\_

Signature \_\_\_\_\_

Date Verified \_\_\_\_\_

**PLEASE MAIL OR FAX COMPLETED FORM TO:  
AAOMS  
MEMBERSHIP SERVICES  
9700 WEST BRYN MAWR AVE.  
ROSEMONT, ILLINOIS 60018-5701  
FAX: 847/678-6286**