



American Association of Oral and Maxillofacial Surgeons

9700 West Bryn Mawr Avenue · Rosemont, Illinois 60018 · Phone: 847/678-6200 · FAX: 847/678-6286 · www.aaoms.org

APPLICATION FOR FELLOWSHIP OR MEMBERSHIP

(Please type or print and submit one copy to Component State OMS Society)

Full Name	Last, Suffix	First	Middle	Degree(s)
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Citizenship: USA	Foreign
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Date and Place of Birth - Month	Day	Year	City and State	Country
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1. ADDRESS INFORMATION Preferred Mailing Address: Home Office

Primary Office Address	Suite/Floor	City	State	Zip Code
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Telephone Number	Fax Number	Business E-mail Address
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Home Address	Apartment/Floor	City	State	Zip Code
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Telephone Number	Fax Number	Home E-mail Address
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2. EDUCATION

Dental	Beginning Date	Graduation Date	Degree
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Name of College or University	City	State
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Medical	Beginning Date	Graduation Date	Degree
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Name of College or University	City	State
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3. POSTGRADUATE TRAINING

OMS Residency	Name of Institution	City	State	Country
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Start Date	Completion Date	Name of OMS Director
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Fellowship	Name of Institution	City	State
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Start Date	Completion Date	Name of OMS Director
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Other Postgraduate	Name of Institution	City	State
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Area of Study	Start Date	Completion Date	Name of OMS Director
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4. Are you a Diplomate of the ABOMS? No Yes Year: _____

5. Have you ever been denied a dental, OMS or medical license? No Yes – *In what state? Please explain and provide documentation.*

6. Have you ever had a dental, OMS or medical license suspended or revoked? No Yes – *In what state? Please explain and provide documentation.*

7. Have you ever been convicted of a felony? No Yes – *Please explain and provide documentation.*
Note: A felony conviction will not automatically bar membership.

8. Present type of practice:

- Currently a Resident Solo Full-time Faculty Group – how many in group? _____
 Federal Service – Branch of Military _____ Rank _____ Grade Level _____
 Veterans Administration - Grade Level _____ Public Health Services - Grade Level _____

9. Dental and Medical Society and Association Memberships:

- American Dental Association – Year Joined _____ ID Number _____
 American Medical Association – Year Joined _____ ID Number _____
 Other: _____ Year Joined _____ ID Number _____

10. Have you ever been subject to any liability, judgment or credentialing action that has been or has the potential for being reported to the National Practitioner Data Bank (NPDB)? *If yes, please explain and use a separate sheet if necessary.*

Case 1 – *describe above* Pending Settled – Date _____

Case 2 – *describe above* Pending Settled – Date _____

Case 3 – *describe above* Pending Settled – Date _____

DECLARATION

I hereby pledge myself, as a condition of Fellowship or Membership in the American Association of Oral and Maxillofacial Surgeons, to pursue my calling with strict regard for the ethics of my profession; to place the welfare of my patients above all else; to endeavor constantly to advance in knowledge by study, interchange of thought; and attendance at clinics and association meetings; to regard scrupulously the interests of my professional colleagues and render willing help to them. It is understood that if I violate this pledge or do not live up to the code of professional conduct, my name will be dropped automatically, or I may be subjected to disciplinary action or subject to expulsion. I understand that this application and all supporting documents remain the property of the Association.

I understand that the certificate of fellowship or membership remains the property of the Association and must be returned when requested.

In addition, for and in consideration of the agreement of the Association to consider my application as foresaid, I hereby and herewith waive any right to any actions at law or equity which might otherwise arise out of any rejection by the Association. I, the undersigned, state that each of the matters and things set forth by me in the above foregoing application is true in substance and in fact; and I understand that each of the matters and things above set forth by me are material representations upon which the American Association of Oral and Maxillofacial Surgeons is entitled in evaluation this application.

Applicant's Signature _____ **Date** _____

- FOR ADMINISTRATIVE USE ONLY -		
ID Number:	Date Rcvd:	Source: Web site