



AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

CONFIDENTIAL

**CERTIFICATION OF COMPLETION OF ORAL AND MAXILLOFACIAL SURGERY
TRAINING AND EVALUATION OF APPLICATION FOR MEMBERSHIP
(PLEASE PRINT OR TYPE)**

Name of Candidate for AAOMS Membership Degree (s)

PRIMARY OFFICE ADDRESS Suite Number City State Zip Code

Telephone Number Fax Number Primary Email Address

HOME ADDRESS Apartment Number City State Zip Code

Telephone Number Fax Number Home Email Address

TO BE COMPLETED BY CHIEF OF TRAINING PROGRAM:

This is to certify that the above-named candidate for membership in the American Association of Oral and Maxillofacial Surgeons has successfully completed the oral and maxillofacial surgery training program at our institution.

Name of Training Program: _____

Address: _____

Completion Date: _____

In order to evaluate the candidate, the Committee on Membership requests your appraisal of his/her qualifications. I have known the candidate for _____ years.

Please comment directly on each of the items below:

CHARACTER: Morals, trustworthiness, ideals

COMPETENCE: Professional capacity, education, fitness

ETHICS: Relations with Medical-Dental colleagues, public

JUDGEMENT: Tact, diplomacy, decisiveness

STABILITY: Self-control, tolerance, social aptitude

ADDITIONAL COMMENTS:

Chief of Training Program

Address

City

State

Zip Code

Signature

Date

MAIL COMPLETED FORM TO:

**AAOMS
MEMBERSHIP SERVICES
9700 W. BRYN MAWR AVE.
ROSEMONT, IL 60018-5701**