



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



Name of Candidate for AAOMS Membership _____

Degree(s) _____

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

Are you a member of your state 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 _____

Zip Code _____

Telephone Number _____

Fax Number _____

Primary E-mail Address _____

HOME ADDRESS _____

Suite/Floor _____

City _____

State/Province _____

Zip Code _____

Telephone Number _____

Fax Number _____

Primary E-mail Address _____

THIS SECTION TO BE COMPLETED BY STATE 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 state OMS society:

Current Status in State Society: Fellow Member Resident Candidate Provisional

Anesthesia Evaluation Date _____ **(must be confirmed for election to full membership)**

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**