American Association of Oral and Maxillofacial Surgeons
Resident Membership Application
For US/Canadian residents and Interns only

Full Name:

First Middle, Last, Suffix Degrees

Email Address: **AAOMS Member ID:**

Date and Place of Birth:

Month, Day, Year, City State Country

☐ Male ☐ Female

If resident is interested in being the program contact for the AAOMS Resident Organization Executive Committee Please check Here → ☐

☐ African/American ☐ American Indian ☐ Asian ☐ Caucasian

☐ Hispanic ☐ Middle Eastern ☐ Other please list: ☐ US Citizen

Dental School:

Name of College or University Start Date Graduation Date Degree

Medical School:

Name of College or University Start Date Graduation Date Degree

Other Post Graduate Training:

Name of College or University Start Date Graduation Date Degree

States Licensed to Practice Medicine/Dentistrv/OMS

Type of License, License Number State Renewal and Expiration Date

Type of License License Number State Renewal and Expiration Date

HomeAddress 1:

HomeAddress 2:

City: **State:** **Zip:**

Phone: **Pager :** **Cell Phone:**

RESIDENT PROGRAM TYPE AND DURATION (please select one) OMS Program Name:

☐ **OMS Certificate 4 years/48 months**

☐ **MD Integrated 6 years/72 months**

☐ **MD Alternative 5-7 years/60-84 months**

☐ **PhD 7-8 years/84-96 months**

☐ **OMS/MS 4 years/48 months**

☐ **Other, please specify:**

Training Start Date: **Training End Date:** **Has Resident obtained MD Yes** ☐ **No** ☐

Prior to OMS residency the resident completed: (please check all that apply)

☐ **N/A** ☐ **AEGD** ☐ **GPR** ☐ **Internship** ☐ **Externship** ☐ **Other**

RETURN TO:
Email: membership@aaoms.org
FAX: 847-678-6286

AAOMS Attn: Membership
9700 W. Bryn Mawr Avenue, Rosemont, IL 60018