AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

CONFIDENTIAL

Certification of Completion of Oral and Maxillofacial Surgery Training and Evaluation of Applicant for Membership

TO BE COMPLETED BY APPLICANT:

Name of Candidate for AAOMS Membership | Degree(s)

PRIMARY OFFICE ADDRESS (including Suite #) | City | State | ZIP Code

Work Email Address | Phone | Fax

HOME ADDRESS | City | State | ZIP Code

Home Email Address | Phone

TO BE COMPLETED BY PROGRAM DIRECTOR OR CHIEF OF TRAINING PROGRAM:

If the candidate is in the federal services, complete this section.

☐ Candidate is employed full-time in the federal services: Rank _____ Grade _____

Branch: ☐ Army ☐ Navy ☐ Air Force ☐ Veterans Administration ☐ Public Health

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."

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Comment directly on each category 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

Return completed form via

Email: membership@aaoms.org

Fax: 847-678-6286 or 847-678-6279

Mail:

AAOMS
Membership Services
9700 W Bryn Mawr Ave
Rosemont, Il 60018-5701

Name of Program Director or Chief of Training Program

Signature Date

Address

City State ZIP Code