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 AFFILIATE MEMBERSHIP

Full Name Last, Suffix First Middle Degree(s)

Date and Place of Birth - Month Day Year City and State Country

1. ADDRESS INFORMATION **Preferred Mailing Address: Home ☐ Office ☐**

Primary Office Address Suite/Floor City State/Province Postal Code

Country Telephone Number Fax Number Business E-mail Address

Home Address Apartment/Floor City State/Province Postal Code

Country Telephone Number Fax Number Business E-mail Address

2. EDUCATION

Dental Beginning Date Graduation Date Degree

Name of College or University City State/Province Country

Medical Beginning Date Graduation Date Degree

Name of College or University City State/Province Country

3. POSTGRADUATE TRAINING

OMS Residency Name of Institution City State/Province Country

Start Date Completion Date Name of OMS Director

Fellowship Name of Institution City State/Province Country

Start Date Completion Date Name of OMS Director

Other Postgraduate Name of Institution City State/Province Country

Area of Study Start Date Completion Date Name of OMS Director

4. Are you a Diplomate of the ABOMS? ☐ No ☐ Yes Year: _____

5. Have you ever had your medical license suspended or revoked? ☐ No ☐ Yes – *Please explain and provide documentation.*

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

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7. Present type of practice

☐ Currently a Resident ☐ Practicing Oral and Maxillofacial Surgeon

8. Dental and Medical Society and Association Memberships:

☐ National OMS Society Year Joined _____ ID Number _____

☐ Other: _____ Year Joined _____ ID Number _____

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** _____

Application fee: $535 - ***Application fees are required at time of submission and will be applied to the current calendar year if received between January 1 – June 30. If application is made between July 1 – December 31, the application fee will be applied to the following year's membership fees. Applications received without an application fee will be held for a maximum of 30 days. If the application fee is not received within that time, a candidate will need to reapply.***

Payment Information: Do Not Send Cash/Payable in U.S. Funds Only.
Check Payments - payable to AAOMS, remit to AAOMS, Attn.: Membership Services Dept., 9700 West Bryn Mawr Avenue, Rosemont, IL 60018.
Credit Card Payments – completed forms may be faxed to AAOMS Headquarters at 847/678-6279.

_ Visa _ MasterCard _ AMEX Credit Card #: _____ Exp. Date: _____

Cardholder Name: _____ Signature: _____

- FOR ADMINISTRATIVE USE ONLY -

ID Number: Date Rcvd: Source: web site