Oral and maxillofacial surgeons:
The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

9700 W. Bryn Mawr Ave.
Rosemont, IL 60018-5701
847-678-6200
800-822-6637
fax 847-678-6286
AAOMS.org

APPLICATION FOR FELLOWSHIP OR MEMBERSHIP

Please type or print clearly.

First Middle Last, Suffix Degree(s)

Citizenship: ☐ I am a U.S. citizen. ☐ Other _____

ADDRESS INFORMATION

Preferred Mailing Address: ☐ Office ☐ Home

☐ *Check here to include your office address in the AAOMS.org OMS Member Directory.*

Company Name

Office Address Suite/Floor City State ZIP Code

Office Phone Fax Work Email

☐ *Check here to include your home address in the AAOMS.org OMS Member Directory.*

Home Address Apartment/Unit City State ZIP Code

Home Phone Cell Personal Email

EDUCATION *Include month and year*

Dental

Beginning Date Graduation Date Degree

Name of College or University City State

Medical

Beginning Date Graduation Date Degree

Name of College or University City State

POSTGRADUATE TRAINING *Include month and year*

OMS Residency

_____

Start Date | Completion Date | Name of OMS Director

_____

Name of Institution | City | State | Country

Fellowship

_____

Start Date | Completion Date

_____

Name of Institution | City | State | Country

Other Postgraduate

_____

Start Date | Completion Date | Area of Study

_____

Name of Institution | City | State | Country

PROFESSIONAL AFFILIATIONS

1. Are you a Diplomate of ABOMS?

☐ No ☐ Yes: Year _____

2. Present type of practice

☐ Currently a resident

☐ Group practice – total in group _____

☐ Veterans Affairs

☐ Federal Service (active duty Army, Navy, Air Force)

☐ Full-time faculty, OMS program:

Program Name _____ Program Director _____

☐ Solo practice

☐ Dental Support Organization (DSO)

☐ Public Health Service

☐ Full-time Faculty, non-OMS program:

3. Dental and Medical Society and Association Memberships

☐ American Dental Association Year joined _____

☐ American Medical Association Year joined _____

☐ Other _____ Year joined _____

ADDITIONAL INFORMATION *Use a separate sheet if necessary.*

4. Have you ever been denied a dental, OMS or medical license?

☐ No ☐ Yes *In what state? Please explain and provide documentation.*

_____

5. Have you ever had a dental, OMS or medical license suspended or revoked?

☐ No ☐ Yes *In what state? Please explain and provide documentation.*

_____

6. Have you ever been convicted of a felony? *Note: A felony conviction will not automatically bar membership.*

☐ No ☐ Yes *Please explain and provide documentation.*

_____

7. Have you ever been subject to any liability, judgment or credentialing action that has been or has the potential for being reported to the National Practitioner Data Bank (NPDB)?

☐ No ☐ Yes *In what state? Please explain.*

_____

Case 1: Describe above.

☐ Pending ☐ Settled: Date _____

_____

Case 2: Describe above.

☐ Pending ☐ Settled: Date _____

_____

Case 3: Describe above.

☐ Pending ☐ Settled: Date _____

Demographics *For statistical purposes only.*

☐ *American Indian*
☐ *Asian*
☐ *Black/African American*
☐ *East Indian*
☐ *Hispanic*
☐ *Middle Eastern/North African*
☐ *Multi-ethnic/Multiracial*
☐ *Native Hawaiian/Other Pacific Islander*
☐ *White/Caucasian*
☐ *Other* _____
☐ *Prefer Not to Answer*

OPTIONAL STATE MEMBERSHIP CONSENT AGREEMENT

☐ Membership in the state OMS society where your primary practice is located is a requirement of AAOMS membership. By marking the checkbox, you are providing consent for AAOMS to share your application with the state OMS society to begin the state membership process.

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 Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND WAIVER OF LIABILITY

By applying for Fellowship or membership to the American Association of Oral and Maxillofacial Surgeons (hereafter referred to as the "Association"), I agree to the following conditions during the processing and consideration of my application, regardless of whether or not I am elected to Fellowship or membership:

1. **Authorization for Release of Information to the Association by Third Parties**
   By my signature below, I authorize the release of otherwise confidential information to the Association and its authorized representatives by sources such as official licensing or regulatory agencies, professional associations, hospitals or other healthcare organizations, educational institutions or other relevant sources.
2. **Waiver of Liability**
   I extend immunity to, and release from any liability, the Association and its authorized representatives for any acts, communications or decisions regarding the processing, consideration and maintenance of my membership application and file.
3. **Acknowledgement of Association Governing Rules and Regulations**
   I acknowledge that my membership status in the Association is based on the Association's Governing Rules and Regulations. I agree to abide by the provisions of the Governing Rules and Regulations and I recognize the Association has the right to limit or terminate my membership status under the Association's Constitution, Bylaws, Policies or Code of Professional Conduct.

Applicant Signature _____ Date _____

For Administrative Use Only

ID Date Received