

## American Association of Oral and Maxillofacial Surgeons

9700 West Bryn Mawr Avenue · Rosemont, Illinois 60018 · Phone: 847-678-6200 · FAX: 847-678-6279 · AAOMS.org

# APPLICATION FOR ALLIED STAFF MEMBERSHIP

Membership available to Allied Staff of U.S. AAOMS Fellows/Members/Candidates

Last Name	First	M	liddle	Degree(s)	
Date of Birth:					
ADDRESS	Month/Day/Year				
Primary Office Address	Suite/Floor	City	State	Zip Code	
Telephone Number	Fax Number	Email Ad	Email Address (unique address required)		
Home Address	Apartment/Floor	City	State	Zip Code	
EMPLOYMENT*					
Name of Sponsoring Member		Company Name			
Address (if other than Primary C	Office, above)	City	State	Zip Code	
EMPLOYMENT DESCRIP	TION:Administrat	tive Personnel_	Clinical Pers	sonnel	
	Practice Administrat	tor/Manager _	Other:		
EDUCATION					
Highest Level of Education C Associates Degree					
CREDENTIALING/CERT	FICATIONS				
Which of the following crede  CCA CCS-P LPN RDA I Other:	_CDACPC RDHRHIA	** * /	CSTDA	AANCE potomy	
PROFESSIONAL MEMBE	RSHIPS (Select all that a	pply)			
AAPCAHIMA	DANBPAHC	COMOT	THER		

### **EMPLOYMENT**

Individuals who are not directly employed by an AAOMS member (ie. billing agency staff or contracted consultants) are not eligible for AAOMS Allied Staff Membership. Only those individual staff members directly employed at a member's practice are eligible.

### APPLICATION PROCESS

Each application must contain the following:

- Payment of one-time non-refundable \$40 application fee for applications received between January 1 September 30; *New applicants only*; not eligible for reinstated membership. Contact AAOMS Membership Department for information on reinstatement.
- Applications received October 1 December 31 pay application fee equal to annual dues of \$55 and receive benefits through the following year. *New applicants only*; not eligible for reinstated membership. Contact AAOMS Membership Department for information on reinstatement.
- Applicant's signature and date

Applications will be processed upon receipt. Candidates will be notified of their membership status within two weeks of application. E-mail membership@aaoms.org if you have any questions.

#### MEMBERSHIP DUES SCHEDULE

The AAOMS membership dues cycle is based on the calendar year (January 1 – December 31). Individuals elected to Allied Staff membership will be assessed dues in the following calendar year. Current annual dues are \$55.

### **DECLARATION**

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 AAOMS Governing Rules and Regulations and I recognize that the Association has the right to limit or terminate my membership status under the Association's Bylaws. I understand that I must notify the Association if I leave the practice of my sponsoring member and eligibility for continued membership will be dependent on employment with another sponsoring member's practice.

Applicant's Signatur	·e			Date
PAYMENT INFORM	MATION	N		
☐ Reinstatement ()	former me	ember) - \$95	☐ New Applic	eant - \$40 Jan - Sept / \$55 Oct - Dec
Check #	□ Visa	☐ MasterCard	☐ Discover	☐ American Express
Credit Card #:			Ex	piration Date:
Name on Credit Card:				Security Code:
Credit Card Billing A	ddress:			
City:		_State/Province:		Zip/Postal Code:
Card Holder's Signatu	ıre:			

Please forward the completed application with payment of non-refundable application fee to:

AAOMS Membership Department

9700 West Bryn Mawr Avenue, Rosemont, Illinois 60018 Or

Fax: 847-678-6279

- FOR ADMINISTRATIVE USE ONLY -						
ID Number:	Date Rcvd:	Source:				