



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
OMS Residency

Include month and year

Start Date	Completion Date	Name of OMS Director
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Name of Institution	City	State	Country
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Fellowship

Start Date	Completion Date
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Name of Institution	City	State	Country
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Other Postgraduate

Start Date	Completion Date	Area of Study
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Name of Institution	City	State	Country
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PROFESSIONAL AFFILIATIONS

1. Are you a Diplomate of ABOMS?

No Yes: Year _____

2. Present type of practice

Currently a resident

Solo practice

Group practice – total in group _____

Dental Support Organization (DSO)

Veterans Affairs

Public Health Service

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

Full-time faculty, OMS program:

Full-time Faculty, non-OMS program:

Program Name _____ Program Director _____

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

Gender *For statistical purposes only.*

Female

Male

I use another term.

I 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