**Application for Membership**

I hereby make application for membership in the Oregon Society of Oral and Maxillofacial Surgeons. If accepted I will comply with the Constitution, By-Laws and Declaration of said Society and will attend and contribute to the Annual Meetings.

Membership Type: Regular Membership (Include $100 application fee)

Resident Membership (place NA if items do not apply)

|  |  |
| --- | --- |
| **Full Name** |  |
| **Street Address** |  |
| **City** |  |
| **State** |  |
| **Zipcode** |  |
|  |  |
| **Daytime Phone** |  |
| **Fax** |  |
| **email** |  |
| **Date of Birth** |  / /  |
| **Place of Birth** |  |
|  |  |
| **Education** **Pre-Dental**  |  / /  |
|  | Institution | Graduation Date | Degree |
|  **Dental** |  / /  |
|  | Institution | Graduation Date | Degree |
| **Post-graduate** |  / /  |
|  | Institution | Graduation Date | Degree (if applicable) |
| **OMS Internship** |  |
|  | Location | Attendance Dates | Total Service |
| **OMS Residency** |  |
|  | Location | Attendance Dates | Total Service |
| **Additional Education/Training** |  |  |  |
|  |  |  |  |
|  **States in which you are licensed to practice and dates of licensure:** |
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|  |  |
|  |  |
| **Military Duty (rank, professional experiences and dates):** |
|  |
|  |
| **Is your practice limited exclusively to Oral and Maxillofacial Surgery?** |  |
| **Number of Years** |  |
|  |
| **Are you a Diplomate of the American Board of Oral and Maxillofacial Surgery?** |  |
| **Number of Years** |  |
|  |
| **Do you hold an oral surgery teaching position in a dental or medical school?** |
|  |
| Name of School | Faculty Position | Date of Appointment |
|  |
| **Dental and Medical Societies to which you belong:** |
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|  |  |
| Signature | Date |

If you have any questions, please call (503) 594-0322..

Please mail completed form with your $100 check (if applicable) to:

 OSOMS - Membership

 8699 SW Sun Place

 Wilsonville, OR 97070-3710

Resident members may fax to: 503-218-2009 or email to oregonoms@gmail.com.