**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** |  | |  | | |  | | |
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| **States in which you are licensed to practice and dates of licensure:** | | | | | | | | |
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| **Military Duty (rank, professional experiences and dates):** | | | | | | | | |
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| **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 | | | |
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| **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.