The Middle Atlantic Society of Oral and Maxillofacial Surgeons

Maryland, New Jersey, Delaware, Pennsylvania, Washington, D.C., Northern Virginia, W. Virginia

MEMBERSHIP APPLICATION

I hereby make application for active ___ or resident___ or military___ (check which) membership in the Middle Atlantic Society of Oral and Maxillofacial Surgeons. If accepted, I will cheerfully obey the Constitution, By-laws and Declaration of said Society and will attend and contribute in the annual meetings.

Note: For active membership please enclose annual dues of $150.00.

There are no dues for resident members however; resident members shall be required to apply for active membership upon completion of residency requirements. A letter from the OMS Program Director attesting current resident status must accompany this application.

Military membership is reserved for oral and maxillofacial surgeons on active duty in the military and stationed within the geographic boundaries of the Middle Atlantic Region. You must be current members in good standing with the ADA and the AAOMS. There are no dues for military members.

Full name: _____ Degree:_____

Office Address: _____

City/State: _____ Zip Code:_____

Office Phone:_____ Fax: _____ E-mail Address:_____

Date and Place of Birth:_____

Pre-dental Education: (Name of College and years of attendance) _____

Dental School and year of Graduation:_____

State in which you are licensed to practice and dates:_____

Post Graduate training: School:_____ Years:_____ Degree:_____

Internship and residencies: _____
(Give name of hospital and dates. Indicate if this was full-time appointment.)

Other graduate courses (give details and dates): _____

Military Duty: Rank:_____

ADA Member #:_____ AAOMS Member #:_____

Do you limit your practice to Oral Surgery exclusively?_____

For how long has your practice been limited in this specialty?_____ Do you have a certificate from the

American Board of Oral Surgery? _____ Date:_____

Do you have any branch of Oral Surgery in a regular dental or medical school?_____

Name of School?_____ Position on the Faculty:_____

Present hospital affiliation:_____

(Give name of hospital and position on staff?) _____

Name dental and medical societies to which you belong:_____

List on a separate sheet an outline of your major contribution to dental literature.

Date:_____ Signature:_____

Sponsored and endorsed by:_____

Please mail completed application to MASOMS, 3912 Arbor Crest Way, Rockville, MD 20853

OFFICE USE ONLY: Application Received Date:_____ 8/20/13