Date_____

Application must be accompanied by an application fee of $25.00.

APPLICATION FOR MEMBERSHIP IN THE

GEORGIA SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

4850 Golden Parkway Suite B-417, Buford, Georgia 30518
Phone: 770.271.0453 Fax: 770.271.0634

Please type or print. (Attach a separate sheet if additional space is needed.)

Last Name First Name Middle Initial

Primary Office Address City State Zip

Primary Office Telephone Primary Office Fax **Email Address**
(By providing your fax number you give GSOMS your approval to fax information to you.)

Secondary Office Address City State Zip

Secondary Office Telephone Secondary Office Fax (By providing your fax number you give GSOMS your approval to fax information to you.)

Home Address Home Telephone

Sex_____ Date of Birth_____ Place of Birth_____

Full Name of Spouse_____

Pre-Dental Education_____Degree_____Date_____

Dental Education_____Degree_____Date_____

Advanced Education in Oral and maxillofacial Surgery:

1st Year of Education:

Institution_____Date_____

Director_____

2nd Year of Education:

Institution_____Date_____

Director_____

3rd Year of Education:

Institution_____Date_____

Director_____

Additional Courses:

States in which you are licensed to practice and dates of Licensure:_____

Military Duty (Branch, rank, professional experiences and dates):

Is your practice limited exclusively to Oral Surgery?_____ Number of years_____ Dates_____

Are you Board Certified in OMS? Yes _____ No _____

Are you a member of the American Association of Oral and Maxillofacial Surgery?_____ Date_____

Are you engaged in research or training of Oral and Maxillofacial Surgery in a dental or medical institution?_____

Institution_____

Faculty Position_____

Names of dental and medical societies to which you belong:

_____

_____

Have you previously applied for membership in this Society, and if so, when?_____

Are you applying for Active, Affiliate or Resident membership?_____

NOTICE TO APPLICANTS:

1. An applicant must be a member of the American Association of Oral and maxillofacial Surgeons (AAOMS) to be eligible for Active membership in the Georgia Society of Oral and Maxillofacial Surgeons. Non-AAOMS applicants must apply for provisional membership.
2. Members of the Georgia Society of Oral and maxillofacial Surgeons shall be governed in ethical matters by the Code of Ethics of the American Dental Association and the Pledge of the American Association of Oral and Maxillofacial Surgeons.
3. An applicant must have an anesthesia permit from the Georgia Board of Dentistry.

Applicants who do not meet these requirements may be voted into Provisional membership pending approval by AAOMS and upon receipt of an anesthesia permit. This status expires if requirements are not met within two years of the date membership is approved.

**I understand that the certificate of membership remains the property of the Society and must be returned when requested if membership is terminated.

_____ _____

Signature of Applicant Date

The committee on membership in preliminarily evaluating your application requires the names of at least two current members of the Georgia Society of Oral and Maxillofacial Surgeons for references.

1. _____
2. _____