Chicago Society of Oral and Maxillofacial Surgeons
An Illinois not-for-profit professional association
2258 Newport Lane, Geneva, IL 60134 / P: 630-408-4676 / F: 331-248-0555
info@chicagosocietyofoms.org / www.chicagosocietyofoms.org

Application for Membership

Contact Information

First Name: _____ Middle: _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Primary Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Please list other offices with address and phone and fax number on a separate sheet.

Email Address: _____

(Email is our primary form of communication. Please provide an email address that is monitored regularly.)

History

Date of Birth: _____ Place of Birth: _____

Type of Practice: ❑Single ❑Partnership ❑Corporation ❑ Association ❑Other

Pre-Dental College: _____ Location: _____

Date of Graduation: _____ Degree: _____

Dental School: _____ Location: _____

Date of Graduation: _____ Degree: _____

Location of Oral & Maxillofacial Internship: _____

Address: _____ Dates of Attendance: _____

Location of Oral & Maxillofacial Residency: _____

Address: _____ Dates of Attendance: _____

Additional Training: _____

Licensure

State of Illinois Dental License Number: _____ Date Issued: _____

Other State License Number(s) and Dates Issued:_____

_____

Is your practice limited exclusively to Oral and Maxillofacial Surgery? ❑Yes ❑No

Number of years: _____ Anesthesia Permit Number: _____

References (Names and Addresses of two Members of CSOMS):

_____

_____

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Is this your first application for CSOMS membership? ❑Yes ❑No (if "no", explain on reverse side)

Membership in the following organizations is required for CSOMS membership. Please indicate membership in each:

❑AAOMS ❑ISOMS (or applicable State Society of OMS)

Other Dental or Medical Societies to which you belong:_____

_____

Are you a diplomate of the American Board of Oral and Maxillofacial Surgery? ❑Yes ❑No Date: _____

Illinois State Board Specialty Number: _____

Do you teach any branch of Oral & Maxillofacial Surgery in a dental or medical school? ❑Yes ❑No

Name of School: _____ Position: _____ Date: _____

Current Hospital Affiliation(s) Staff Memberships:

Hospital: _____ City: _____ Position: _____

Hospital: _____ City: _____ Position: _____

Hospital: _____ City: _____ Position: _____

I hereby pledge, as a condition of membership in the Chicago Society of Oral and Maxillofacial Surgeons, to conduct myself 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 society meetings; to regard scrupulously the interest of my professional colleagues.

I understand that if I violate this pledge or do not live up to the Code of Professional Conduct and Official Advisory Opinion of the American Association of Oral and Maxillofacial Surgeons, charges against me shall be brought before the Executive Council and the Chicago Society of Oral and Maxillofacial Surgeons and I shall be liable to expulsion. I promise to return to the Society any Certificate of Membership if at any time I cease to be a member.

In consideration of CSOMS processing my application for membership, I grant permission and consent for the Society to obtain information regarding hospital staff privileges and actions relating thereto and all information from former and present professional society affiliations, specialty organizations, schools and other organizations providing professional training.

I hereby affirm and represent that the information contained in this application is true to the best of my knowledge. I expressly grant the CSOMS the authority to communicate and share any and all the foregoing information with any person or entity as the Society deems appropriate.

Signature: _____ Date: _____

Applications must be returned to: CSOMS, 2258 Newport Lane, Geneva, IL 60134; or info@chicagsocietyofoms.org, along with dues payment of $225.

Payment method: Enclosed Check _____ Credit Card _____

Credit Card Number: _____ Exp.:_____ Security Code:____ Billing Zip:_____

Signature: _____ E-mail: _____

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Office Use Only: Date Received: _____ Action by Executive Council: _____

❑Active ❑Associate ❑Honorary ❑Other _____

Action by CSOMS Membership: _____ Date: _____