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):

____

____

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

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: _____________________

A**pplications must be mailed to: CSOMS, 2258 Newport Lane, Geneva, IL 60134, along with dues payment of $180.**

Payment method: Enclosed Check __________ Credit Card _________

Credit Card Number: _________________________________ Exp.:______ Security Code:____ Billing Zip:____________

Signature: ____ E-mail: _____________________________________

****

Office Use Only: Date Received: __________________ Action by Executive Council: _______________________________

❑Active ❑Associate ❑Honorary ❑Other ____

Action by CSOMS Membership: ____ Date: ___________________________