

Greetings: Be it known that by virtue of the authority vested, the Regents hereby invite you to apply for membership or fellowship:

		DATE:	
NAME:		DEGREE:	
NAME AS YOU WISH IT TO APPEAR ON CERTIFICATE:			
OFFICE ADDRESS:		PHONE:	
		FAX:	
		ZIP:	
E-MAIL ADDRESS:			
HOME ADDRESS:		PHONE:	
		ZIP:	
BIRTHDATE:		MILITARY SERVICE:	
EDUCATION			
NAME AND LOCATION OF SCHOOL		MONTH/YEAR FROM-TO	DEGREE(S)
PRE-DENTAL			
DENTAL			
GRADUATE			
RESIDENCY			
INTERNSHIPS AND RESIDENCIES			
NAME OF HOSPITAL/LOCATION		MONTH/YEAR FROM-TO	DEGREE(S)
OTHER POSTGRADUATE TRAINING/EXPERIENCE: (FELLOWSHIP, ASSISTANTSHIPS, RESEARCH, GRANTS, ETC.)			
SPECIALTY BOARD:		DATE:	
HOSPITAL APPOINTMENTS: (LIST NAME OF HOSPITAL, LOCATION, AND TITLE)			
AWARDS AND HONORS:			

PROFESSIONAL SOCIETY MEMBERSHIPS: (LIST NAME OF SOCIETY AND YEAR OF MEMBERSHIP)			
PRESENT POSITION: (E.G. PRIVATE PRACTICE, TEACHING APPOINTMENT, ETC.)			
GENDER:*	MALE	<input type="checkbox"/>	
	FEMALE	<input type="checkbox"/>	
HAVE YOU HAD ANY INVOLUNTARY CHANGES IN STATUS OF ANY LICENSURE, CERTIFICATION, OR REGISTRATION, OR HAVE YOU EVER HAD ANY VOLUNTARY OR INVOLUNTARY RELINQUISHMENT OF SUCH LICENSURE, CERTIFICATION, OR REGISTRATION?	YES	<input type="checkbox"/>	
	NO	<input type="checkbox"/>	
HAVE YOU HAD ANY VOLUNTARY OR INVOLUNTARY CHANGES IN STATUS OF DEA CERTIFICATION (OR ITS EQUIVALENT AUTHORIZATION TO PRESCRIBE DRUGS)?	YES	<input type="checkbox"/>	
	NO	<input type="checkbox"/>	
HAVE YOU EVER BEEN CONVICTED OF A FELONY?	YES	<input type="checkbox"/>	
	NO	<input type="checkbox"/>	
IF YOU ANSWERED "YES" TO ANY ABOVE, PLEASE EXPLAIN IN DETAIL:			
HAVE YOU EVER COMPLETED AN APPROVED RESIDENCY IN ORAL AND MAXILLOFACIAL SURGERY? LIST PROGRAM (AND EXPECTED DATE OF COMPLETION FOR CURRENT RESIDENTS):	YES	<input type="checkbox"/>	
	NO	<input type="checkbox"/>	
<u>PLEASE SUBMIT A CURRENT CURRICULUM VITAE AND A LIST OF SCIENTIFIC PAPERS, ESSAYS AND THESES YOU MAY HAVE WRITTEN</u>			
IN MAKING APPLICATION TO THE AMERICAN COLLEGE OF ORAL AND MAXILLOFACIAL SURGEONS, I AGREE TO ABIDE BY THE COLLEGE'S BYLAWS AND TO SUPPORT ITS PURPOSES AND OBJECTIVES. I UNDERSTAND THAT ALL INFORMATION SUBMITTED HEREIN IS THE SOLE PROPERTY OF THE COLLEGE			
SIGNATURE OF APPLICANT:			
APPLICATION FEE AND INFORMATION:			
APPLICATIONS FOR MEMBERSHIP IN ACOMS ARE REVIEWED QUARTERLY BY THE MEMBERSHIP COMMITTEE AND APPROVED BY THE BOARD OF REGENTS. UPON ACCEPTANCE INTO THE COLLEGE YOU WILL RECEIVE A CERTIFICATE OF MEMBERSHIP AND BE ASSESSED MEMBERSHIP DUES FOR THE REMAINDER OF THE YEAR. ALL APPLICANTS ARE SUBJECT TO A \$50 APPLICATION FEE (\$25 FOR RESIDENTS), REGARDLESS OF THE FINAL STATUS OF THEIR APPLICATION. PLEASE SUBMIT PAYMENT BELOW			
METHOD OF PAYMENT (CIRCLE)	VISA/MASTERCARD	AMERICAN EXPRESS	CHECK
CARD NUMBER:			
EXPIRATION DATE:		CVV:	
NAME ON CARD:			
PLEASE RETURN COMPLETED APPLICATION TO:			
THE AMERICAN COLLEGE OF ORAL AND MAXILLOFACIAL SURGEONS 2025 M ST. NW, SUITE 800 WASHINGTON, DC 20036 PHONE: (202) 367-1182 OR (800) 522-6676 FAX: (202) 367-2182 WWW.ACOMS.ORG INFO@ACOMS.ORG			
<i>*COMPLETION OF THIS INFORMATION IS OPTION AND WILL BE USED FOR STATISTICAL PURPOSES ONLY</i>			