



Massachusetts Society of Oral and Maxillofacial Surgeons

A Component Society of the
American Association of Oral and Maxillofacial Surgeons

New Member Application

Applicant Information

Applicant Name:

First *Middle* *Last* *Credentials*

Practice Name:

Practice Address:

Street:

City, State Zip:

Phone Number:

Office:

Cell:

Email Address:

Home Address:

Street:

City, State Zip:

Date of Birth:

Place of Birth:

Name of Sponsors*

#1

#2

** Sponsors must be current members of the Massachusetts Society of Oral and Maxillofacial Surgeons and should forward a letter of recommendation on behalf of the applicant.*

American Association of Oral & Maxillofacial Surgeons (AAOMS)

Membership Status:



Massachusetts Society of Oral and Maxillofacial Surgeons

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Education & Experience

Undergrad School: _____

Degree: _____ **Grad Date:** _____

Dental School: _____

Degree: _____ **Grad Date:** _____

OMS Training Program: _____

Program Director: _____ **Years:** _____

Other Graduate School: _____

Degree: _____ **Grad Date:** _____

Internship/s: _____
Institution & Dates

Institution & Dates

Residency/ies: _____
Institution & Dates

Institution & Dates

Military Service: _____
Branch *Dates of active duty*



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Oral & Maxillofacial/Professional Experience

Exclusive Private Practice of Oral & Maxillofacial Surgery Began:

Date: _____ Location: _____

Teaching Positions

Location: _____ Years: _____

Location: _____ Years: _____

Location: _____ Years: _____

Hospital Appointments

Location: _____ Years: _____

Location: _____ Years: _____

Location: _____ Years: _____

Publications *Attach sheet if necessary*

Title: _____

Publication: _____ Date: _____

Title: _____

Publication: _____ Date: _____

Title: _____

Publication: _____ Date: _____



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Professional Memberships

Memberships in Professional Societies:

Organization: _____ Years: _____

Organization: _____ Years: _____

Organization: _____ Years: _____

I hereby pledge that, as a member of the Massachusetts Society of Oral and Maxillofacial Surgeons, I will:

- Place the welfare of my patients above all else
- Pursue my calling with strict regard for the ethics of my profession
- Strive to remain current in my practice of oral and maxillofacial surgery through independent study and attendance at clinical programs and society meetings
- Respect the interests of my professional colleagues and render them willing assistance

I understand that my membership in the Massachusetts Society of Oral and Maxillofacial Surgeons is subject to, and protected by, compliance with the American Association of Oral and Maxillofacial Surgeons ***Code of Professional Conduct***.

Name: _____

Signature: _____ **Date:** _____

Return Form: Massachusetts Society of Oral & Maxillofacial Surgeons
2 Willow St. Ste 200
Southborough, MA 01745

Or: spilling@massdental.org

Application Fee:

- Practicing 1-3 years - \$15
- Practicing 4-7 years - \$75
- Practicing 7+ years - \$150

Received by: _____ Date: _____ Fee Enclosed: _____