Date Received _____

1st Reading Date _____

Second Reading Date _____

Application Complete _____

FOR OFFICE USE ONLY

1. Application must be typewritten or printed in ink

2. A non-refundable application fee of $45 must accompany application

APPLICATION FOR ACTIVE MEMBERSHIP IN THE

NEW JERSEY SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

EMAIL: _____ Date _____

1. Full name _____ _____ _____ U.S. Citizen ❑ Yes ❑ No
LAST FIRST MIDDLE

2. a. Office Address: Street _____ City _____

State _____ Zip _____ Telephone Number _____

b. Home Address: Street _____ City _____

State _____ Zip _____ Telephone Number _____

3. Date and place of birth: _____
MONTH DAY YEAR CITY STATE

4. Education

a. Predental: _____ _____ _____
NAME OF COLLEGE OR UNIVERSITY DATE OF GRADUATION DEGREE

b. Dental: _____ _____ _____
NAME OF COLLEGE OR UNIVERSITY DATE OF GRADUATION DEGREE

5. Advanced education in Oral and Maxillofacial Surgery

1st year of education – From _____ to _____

_____
NAME OF INSTITUTION CITY STATE

Name of Director of Oral and Maxillofacial Surgery _____

2nd year of education – From _____ to _____

_____
NAME OF INSTITUTION CITY STATE

Name of Director of Oral and Maxillofacial Surgery _____

3rd year of education – From _____ to _____

_____
NAME OF INSTITUTION CITY STATE

Name of Director of Oral and Maxillofacial Surgery _____

4th year of education – From _____ to _____

NAME OF INSTITUTION CITY STATE

Name of Director of Oral and Maxillofacial Surgery _____

a. Enclose verification of oral and maxillofacial Surgery training from Directors of all programs listed above.

b. Additional credit courses and degree(s) if any _____

6. States in which you are licensed to practice and dates of licensure and please enclose a copy of your medical/dental license._____

7. Military duty (Rank, professional experience and inclusive dates) _____

8. Do you limit your practice to oral and maxillofacial surgery? _____

Number of Years _____ Dates_____

9. Are you a Diplomate of the American Board of Oral and Maxillofacial Surgery? _____ Date _____

Type of Practice: Solo_____ Group_____ Military _____ Teaching _____ Other _____

10. Are you engaged in research or teaching of oral and maxillofacial surgery in a dental or medical institution?_____

Name of Institution _____ Your faculty position _____

Date of appointment _____

11. Dental and medical societies to which you belong: ADA ☐YES _____ YEAR

☐NO _____ A.D.A. ID NUMBER

Others _____

12. Have you previously applied for NJSOMS membership! _____

If so, when? _____

13. Enclose a typewritten copy of your Curriculum Vitae including publications.

14. Present hospital affiliations:

HOSPITAL	STAFF POSITION	DATE OF APPOINTMENT	HOSPITAL ADMIN.
HOSPITAL ADDRESS	CITY	STATE	ZIP CODE
HOSPITAL	STAFF POSITION	DATE OF APPOINTMENT	HOSPITAL ADMIN.
HOSPITAL ADDRESS	CITY	STATE	ZIP CODE
HOSPITAL	STAFF POSITION	DATE OF APPOINTMENT	HOSPITAL ADMIN.
HOSPITAL ADDRESS	CITY	STATE	ZIP CODE

15. The Committee on Membership in evaluating your application **requires three letters of reference** of current members of the New Jersey Society of Oral and Maxillofacial Surgeons. Please list names and addresses of references below. Federal Services applicants may list three active members regardless of geographical location.

_____ years known _____
NAME

STREET ADDRESS

CITY STATE ZIP CODE

_____ years known _____
NAME

STREET ADDRESS

CITY STATE ZIP CODE

_____ years known _____
NAME

STREET ADDRESS

CITY STATE ZIP CODE

Reminder to Enclose

- ❒ *1. Application fee of $45.00*
- ❒ *2. Enclose verification of OMS Directors (see#5a)*
- ❒ *3. Copy of Medical/Dental License (see#6)*
- ❒ *4. Curriculum Vitae (see#13)*
- ❒ *5. Three Letters of Reference (see#15)*

Membership Application
DECLARATION

I hereby pledge myself, as a condition of membership in the New Jersey Society of Oral and Maxillofacial Surgeons, to pursue my calling with strict regard to 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 association meetings; to regard scrupulously the interests of my professional colleagues and render willing help to them.

It is understood that if I violate this pledge or do not live up to the code of professional conduct, my name will be dropped automatically, or I may be subjected to disciplinary action or subject to expulsion.

I understand that this application and all supporting documents remain the property of the Society.

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

In addition, for and in consideration of the agreement of the Society to consider my application as aforesaid, I hereby and herewith waive any right to any actions at law or inequity which might otherwise arise out of any rejection by the Society of my application.

I the undersigned, being duly sworn on oath, depose and state that each of the matters and things set forth by me in the above foregoing application is true in substance and in fact; and I understand that each of the matters and things set forth by me are material representations upon which the New Jersey Society of Oral and Maxillofacial Surgeons is entitled to rely in evaluation this application.

_____
YOUR SIGNATURE

County of _____

State of _____

Subscribed and sworn to before me this _____ day of _____ , 19_____

_____
NOTARY PUBLIC

Return this application and all supporting materials to the Membership Secretary, New Jersey Society of Oral and Maxillofacial Surgeons.

NJSOMS
619 AMBOY AVE.
EDISON, NJ 08837