

Chicago Society of Oral and Maxillofacial Surgeons

An Illinois not-for-profit professional association

Application for Membership

First Name _____ Middle _____ Last _____

Home Address _____ City _____ ST _____ Zip _____

Home Phone (_____) _____

Primary Office _____ City _____ ST _____ Zip _____

Office Phone _____ Office Fax _____

Please list other offices with address and phone and fax numbers on another sheet.

Email Address _____ (at _____ Home _____ Work _____ Both)

Date of Birth _____ Place of Birth _____

Type of Practice _____ Single _____ Partnership _____ Corporation _____ Association _____ Other

Pre-dental College _____ Location _____

Date of Graduation _____ Degree _____

Dental School _____

Date of Graduation _____ Degree _____

Location of Oral & Maxillofacial Internship _____

Address _____ Dates of Attendance _____

Location of Oral & Maxillofacial Residency _____

Address _____ Dates of Attendance _____

Additional Training _____

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? _____

Number of years _____ Anesthesia Permit Number _____

Names/References and Addresses of two Members of CSOMS _____

Chicago Society of Oral and Maxillofacial Surgeons

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

Are you a member of _____ ADA _____ AAOMS _____ ISOMS (or YOUR State Society of OMS)

_____ ISDS Component Branch _____
(Membership in the above organizations is required for CSOMS membership.)

Other Dental or Medical Societies to which you belong _____

Are you a diplomate of the American Board of Oral and Maxillofacial Surgery? _____ Date _____

Illinois State Board Specialty Number _____

Do you teach any branch of Oral & Maxillofacial Surgery in a dental or medical school? _____

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, 222 E. Wisconsin Ave., Suite. 214,
Lake Forest, IL 60045 along with the \$100 annual dues payment.**

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

_____ Active _____ Associate _____ Honorary _____ Other (_____)

Action by CSOMS Membership _____ Date _____