



Membership Application

First Name _____ MI _____ Last _____

Home Address _____ City _____ ST _____ Zip _____

Home Phone _____ Fax _____

Primary Office _____ City _____ ST _____ Zip _____

Office Phone _____ Office Fax _____

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

Email _____

Date of Birth _____ Place of Birth _____

List Names of Your Current Practice Associates, if any:

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 _____ IL Anesthesia Permit Number _____



Membership Application, continued

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

Are you a member of ____ ADA ____ AAOMS (Required) Date you joined _____
____ ISDS Component Branch _____

Other Dental or Medical Societies to which you belong _____

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

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

Name of School _____ Position _____

Date of Appointment _____ Department Head _____

Current Hospital Affiliation(s)

Hospital _____ City _____ Position _____

Hospital _____ City _____ Position _____

Hospital _____ City _____ Position _____

I hereby pledge as conditions of membership in the Illinois Society of Oral and Maxillofacial Surgeons to

- pursue my calling with strict regard for the ethics of my profession;
- place the welfare of my patients above all else;
- endeavor constantly to advance in knowledge by study, interchange of thought and attendance at clinics and Society meetings;
- regard scrupulously the interests of my professional colleagues and render willing help to them commensurate with services rendered;
- avoid the division of fees in any form, either by collecting fees for others referring patients to me or by permitting them to collect my fees for me, or in any way compensating any person referring patients to me.
- support the Constitution and Bylaws of ISOMS

I understand that if I violate this pledge or do not live up to the code of professional ethics, my name will be dropped from the membership rolls of ISOMS, and that the Certificate of Membership remains the property of ISOMS and must be returned when requested. I also understand that an office anesthesia evaluation is required prior to attaining active membership status and that periodic re-evaluation is a requirement for continued membership.

In consideration of ISOMS 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 ISOMS 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 sent to ISOMS with the \$50 Application fee, the \$50 Anesthesia Evaluation fee and the \$200 annual dues. (One check for \$300 made out to ISOMS is acceptable.) **Fax to 847-574-0445 or mail to: ISOMS, 1025 W. Everett Rd., Suite 4, Lake Forest IL 60045** (Tel. 847-482-0222) ISOMS99@aol.com