# TENNESSEE SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

NOTICE TO APPLICANTS:

MEMBERSHIP SHALL CONSIST OF DENTISTS WHO LIMIT THEIR PRACTICE TO ORAL AND MAXILLOFACIAL SURGERY. AN APPLICANT IS ELIGIBLE TO FILE APPLICATION AFTER HIS OR HER FINAL YEAR OF APPROVED TRAINING IN ORAL AND MAXILLOFACIAL SURGERY.

DATE: ____________________________

1. FULL NAME ______________________________________________ U.S. CITIZEN ______YES ______ NO
   LAST FIRST MIDDLE

2. OFFICE ADDRESS ______________________________________________
   STREET CITY STATE ZIP PHONE

   HOME ADDRESS ______________________________________________
   STREET CITY STATE ZIP PHONE

3. DATE AND PLACE OF BIRTH ______________________________________________
   MONTH DAY YEAR CITY STATE

4. EDUCATION:

   PRE-DENTAL ______________________________________________
   NAME OF COLLEGE/UNIVERSITY DATE OF GRADUATION DEGREE

   DENTAL ______________________________________________
   NAME OF SCHOOL DATE OF GRADUATION DEGREE

5. ADVANCED EDUCATION IN ORAL AND MAXILLOFACIAL SURGERY

   FROM ______________________________ TO ______________________________

   ______________________________________________
   NAME OF INSTITUTION CITY STATE

   ______________________________________________
   NAME OF DIRECTOR OF ORAL AND MAXILLOFACIAL SURGERY

6. ADDITIONAL COURSES AND DEGREES, IF ANY ______________________________________________

   ______________________________________________

   ______________________________________________

7. Are you licensed in the state of Tennessee? Dental: ________ YES ________ NO; Medical: ________ YES ________ NO

8. Do you have an oral and maxillofacial surgery specialty license in Tennessee? ________ YES ________ NO

9. MILITARY DUTY (RANK, PROFESSIONAL EXPERIENCE AND INCLUSIVE DATES) ______________________________

   ______________________________________________

10. Is your practice limited exclusively to oral and maxillofacial surgery? ________ YES ________ NO

11. Are you a diplomate of the American Board of Oral and Maxillofacial Surgery? ________ YES ________ NO

    DATE: ______________________________________________

12. Are you engaged in Research or training of Oral and Maxillofacial Surgery in a dental or medical institution?

________ YES ________ NO ______________________________________________
NAME OF INSTITUTION

______________________________________________
YOUR FACULTY POSITION DATE OF APPOINTMENT

13. Are you a member of A.A.O.M.S.? ________ YES ________ NO

If yes, what type of membership? ______________________________________________

14. Have you previously applied for membership in T.S.O.M.S and if so, when? ______________________

DECLARATION:

I will abide by the code of professional conduct and official advisory opinions of the A.A.O.M.S.

______________________________
YOUR SIGNATURE

THE CREDENTIALS COMMITTEE ON MEMBERSHIP IN PRELIMINARILY EVALUATING YOUR APPLICATION REQUIRES THE NAMES AND COMPLETE ADDRESSES OF AT LEAST THREEE CURRENT FELLOWS OF THE AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS FOR REFERENCES, EXCLUSIVE OF THE CHIEF OF YOUR ORAL SURGERY TRAINING PROGRAM.

______________________________________________ YEARS KNOWN ________
NAME

______________________________________________
STREET

______________________________________________
CITY STATE ZIP

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______________________________________________ YEARS KNOWN________
NAME

______________________________________________
STREET

______________________________________________
CITY STATE ZIP

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______________________________________________
NAME

______________________________________________
STREET

______________________________________________
CITY STATE

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