Applicant: ______________________________ Date of Application: ______________

TO: CALAOMS Applicant

FROM: Pamela Congdon, CAE, IOM
CALAOMS Membership Services
pamela@calaoms.org

SUBJECT: **Requirements for CALAOMS Membership**

Thank you for requesting an application for membership to the California Association of Oral and Maxillofacial Surgeons. In order for your application to be processed expeditiously, the following items must also be sent to CALAOMS. Please mark an "X" next to each item that you are enclosing with the application. Remaining items may be sent at a later date. Thank you.

___ $250.00 Application Fee (Waived for CALAOMS Resident Members or anyone applying in the year they complete their residency program)
___ Black and White Passport Photo (Optional)
___ 2 Letters of Recommendation
___ Copy of your OMS Diploma
___ Copy of your Dental School Diploma
___ Copy of Medical School Diploma (if MD)
___ Copy of State Dental License
___ Copy of State Medical License (if MD)
___ Proof of Liability Coverage
___ Copy of Anesthesia Permit
___ Verification of General Anesthesia On-Site Evaluation
___ Verification of Membership (or Application) in AAOMS (American Association of Oral & Maxillofacial Surgeons)

Please submit all information to CALAOMS, 950 Reserve Drive, Suite 120, Roseville, CA 95678 or fax to (916) 772-9220. If you have questions please call toll free (800) 500-1332 or (916) 782-1332.

Application fee may be paid by check or credit card.

____Check for $_________enclosed

____Please charge $_________ to the following ___Visa or ___MasterCard account

Account # __________ __________ __________ __________

Expiration Date ____/____ Three digit number on back of card ________

Name on card ____

Billing address of card ____

Signature ____

950 Reserve Drive Suite 120
Roseville, CA 95678
T 916.783.1332
F 916.772.9220

Application for Membership

This application is to be returned to the administrative office of the California Association of Oral & Maxillofacial Surgeons along with the items listed on the enclosed checklist.

I hereby make application for membership to the California Association of Oral & Maxillofacial Surgeon. If accepted, I will obey the Constitution, Bylaws and Pledge of the organization and will attend and contribute to the meetings.

Please type or print. **Date:** __________________

Full Name: ____
Last First Middle

Sex: M F **U. S. Citizen:** Yes No

Marital Status: M S W D **Spouse's Name:** ____________________

Children's Name(s) & Age ____________________

____

____

Date of Birth: __________________ **Place of Birth:** ____________________
City State/Country

Home Address: ____
Street Apt. #

____
City State Zip

____
Telephone E-Mail

Primary Office Address: ____
Street Suite

____
City State Zip

____
Telephone Fax E-Mail

Affiliated Practitioner(s): ____

Second Office Address: ____
Street Suite

____
City State Zip

____
Telephone Fax E-Mail

Education

Predental: ____
Name of College/University   Graduation Date   Degree

Dental: ____
Name of College/University   Graduation Date   Degree

Medical: ____
Name of College/University   Graduation Date   Degree

Other: ____
Name of College/University   Graduation Date   Degree

Advanced Education in Oral and Maxillofacial Surgery

______________________________ ______________________________
Name of Institution   Address of Institution

______________________________ ______________________________
Inclusive Dates   Program Director

Fellowship

______________________________ ______________________________
Name & Type of Fellowship   Status (Intern, Resident, etc.)

______________________________ ______________________________
Inclusive Dates   Program Director

California Dental License Number: ___________________ Date of Licensure: ______________________

California Medical License Number: __________________ Date of Licensure: ______________________

General Anesthesia Permit Number: __________________ Date of Issuance: ______________________

Other states in which you are licensed to practice

____
State   License Number   Date of Licensure

____
State   License Number   Date of Licensure

Do you limit your practice to oral and maxillofacial surgery?   Yes   No

Present type of practice: ___Solo   ___Group   ___Full-time Teaching   ___Federal Service (Branch___________________)

Have you ever applied for membership to the California Association of Oral and Maxillofacial Surgeons or its component
"
societies prior to this application?   Yes   No   (If yes, date _____________)

Are you a member of the American Association of Oral and Maxillofacial Surgeons?   Yes   No   (If yes, date ___________)

Are you a diplomate of the American Board of Oral and Maxillofacial Surgery?   Yes   No   (If yes, date___________)

Are you engaged in research or teaching oral and maxillofacial surgery in a medical or dental institution or hospital? Yes No

Name of Institution: ____

Your Faculty Position ____

Date of appointment: ____

List the dental and medical societies to which you belong:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

List your major contributions to the dental/medical literature (use separate sheet if necessary):

____

____

____

____

____

List chronologically all professional activities following completion of your oral and maxillofacial training including all location of practice(s). (Use separate sheet if necessary):

____

____

____

____

____

Present Hospital Affiliations:

____

Hospital """""""""""""""""Position """"""Date of Appointment """"Hospital Administrator

____

Hospital Address City State Zip

____

Hospital """""""""""""""""Position Date of Appointment Hospital Administrator

____

Hospital Address City State Zip

____

Hospital """""""""""""""""Position """""Date of Appointment """"""""""""""""""""Hospital Administrator

____

Hospital Address City State Zip

Please list all your professional liability insurance carriers for the past five years beginning with your present carrier.

____

Present professional liability carrier Amount of Coverage

____

Policy Number Expiration Date

____

Prior professional Liability carrier

____

Prior professional Liability carrier

Have you ever been denied professional liability insurance or has your premium been modified or surcharged because of claims experience? """" Yes """" No

Have you applied or are you a member of your local dental society? Yes No

If yes, name of local dental society ____

If your answer to any of the following question is "yes", please give full details on a separate sheet of paper.

Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied or subjected to probationary conditions, or have proceedings toward any of those ends ever been instituted?

Yes No

Have you ever been denied membership to a hospital staff or had your privileges limited, reduced, suspended or subject to probationary conditions, or have proceedings toward any of those ever been instituted or recommended by a standing medical staff committee or governing board?

Yes No

Have you ever been denied membership or renewal thereof or been subject to any disciplinary action in any dental/medical organization or professional society, local or state, or have proceedings toward any of those ends ever been instituted?

Yes No

Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended or reduced, or have proceedings toward any of those ends ever been instituted?

Yes No

Has your Drug Enforcement Agency Permit for dispensing controlled substances ever been denied, revoked, suspended or not renewed, or have proceedings toward those ends ever been instituted?

Yes No

Have you ever voluntarily relinquished a medical staff membership, a clinical privilege, a professional license or narcotics registration under threat of disciplinary action?

Yes No

Is any professional liability litigation pending against you?

Yes No

Is any criminal litigation pending against you?

Yes No

References:

The Committee on Membership, in evaluating your application, requires reference names and complete addresses of at least two current members of the California Association of Oral & Maxillofacial Surgeon who are located in your area of practice. Federal Service applicants may list three active members regardless of geographical location.

____

Name   Years known

____

Street Address   City   Telephone

____

Name   Years known

____

Street Address   City   Telephone

____

Name   Years known

____

Street Address   City   Telephone

Membership Applicant's Statement

I certify that I have never been disciplined by, expelled from, or refused membership in a dental or medical society/association or an oral and maxillofacial surgery society/association, or a hospital medical/dental staff except as explained on my attached letterhead stationery.

I certify that I will abide by the Constitution and Bylaws of the California Association of Oral & Maxillofacial Surgeon and, if I am elected to membership, I agree that my membership in this organization shall be conditioned upon my compliance with the Constitution and Bylaws and the professional ethics of same, as well as, the Constitution and Bylaws and professional ethics of the American Association of Oral and Maxillofacial Surgeons. I further agree that I will recognize the authorized officers of this association as the proper authorities to interpret any doubtful points of professional ethics and will at all times abide by and be governed by their interpretations.

I understand and acknowledge that membership in this organization is a privilege conferred upon a candidate, and that the organization is in no way obligated to approve any application or to explain its action of approval or disapproval. The organization has no obligation to return application fees if approval is not granted.

I am aware that the information submitted in this application and any additional information may be verified. I hereby authorize the California Association of Oral & Maxillofacial Surgeon to make known to hospitals and other dental and medical organizations any information the association may have, and authorize hospitals and other dental and medical organizations to release such information as they may have concerning me.

Signature: ____

Printed Name: ____

Date: ____

CALIFORNIA ASSOCIATION of
ORAL & MAXILLOFACIAL SURGEONS

950 Reserve Drive Suite 120
Roseville, CA 95678
T 916.783.1332
F 916.772.9220

Pledge of the Association

As an elected member of the California Association of Oral & Maxillofacial Surgeon, I pledge that I will, to the best of my ability, strive to follow its ideals, bylaws and regulations in my professional career.

I pledge to place the welfare of my patients above all else, to keep current with the latest scientific literature and advances, to continue to improve my surgical and didactic skills through continuing education, to practice in conformity with the bylaws of CALAOMS to seek counsel from colleagues when indicated and to refer to the appropriate practitioner any case which I do not feel qualified to treat.

I further pledge to maintain the highest standard of ethics and moral behavior consistent with the bylaws and precepts of CALAOMS.

Should I willfully fail in the fulfillment of this pledge, I agree to relinquish my membership.

Signature_________________________________

Printed Name______________________________

Date______________________

950 Reserve Drive Suite 120
Roseville, CA 95678
T 916.783.1332
F 916.772.9220

Contact Authorization

Beginning August 25, 2003, as part of the Telephone Consumer Protection Act (Do Not Call Law), new Federal Communications Commission (FCC) regulations prohibit certain businesses and professional organizations, including professional associations like the California Association of Oral & Maxillofacial Surgeon (CALAOMS), from calling, faxing or e-mailing information about its programs and services to members, vendors and others without a signed consent form on file.

In order to receive important information about CALAOMS, including continuing education programs, the Annual Meeting, conferences, new programs and product initiatives, you must complete and return this form to the CALAOMS central office. Without a signed consent form on file, we will not be able to send important information to you.

CALAOMS must have your signature on file. Note that CALAOMS never sells or shares its members' telephone, fax or e-mail contact information to outside parties. Please acknowledge your consent by signing below and returning this form to CALAOMS.

I give my consent for CALAOMS to contact me by telephone, fax or e-mail regarding any CALAOMS issues or offerings.

My preferred fax number is ____

Do you want this fax number published in the CALAOMS Directory? ___yes ___no

My preferred e-mail address is____

Do you want this e-mail address published in the CALAOMS Directory? ___ yes ___ no

Printed Name ____

Signature ____

Date ____________________