

Dear Doctor:

We would like to invite you to become a Resident Member of the California Association of Oral and Maxillofacial Surgeons (CALAOMS). We are a non-profit organization established to promote the profession of oral and maxillofacial surgery through service and education. CALAOMS is the California state component of the American Association of Oral and Maxillofacial Surgeons (AAOMS).

Being a Resident Member of CALAOMS has the following benefits:

- Resident Members do not have to pay dues
- Resident Members may attend many CALAOMS meetings at no charge or at a reduced charge
- Resident Members receive the CALAOMS newsletter, “The Compass” at no charge
- Resident Members who apply for regular CALAOMS membership after completing their residency do not pay the \$250 application fee.
- Resident Members qualify for a reduced dues structure for regular CALAOMS membership in their first two years of regular membership.

We are hopeful that you will complete the enclosed application and become a Resident Member of CALAOMS. If you have completed your residency and would like to join CALAOMS as a Regular Member or if you have any questions, please call Pam at the CALAOMS office, (800) 500-1332.

We look forward to serving you as a Resident Member of CALAOMS.

Sincerely,

Pamela Congdon, CAE, IOM  
Membership Services

Dennis Gorospe, DDS  
Membership Chairperson

Enclosure: Resident Membership Application



CALIFORNIA ASSOCIATION of  
ORAL & MAXILLOFACIAL SURGEONS

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

**Application for Resident Membership**

This application is to be returned to the administrative office California Association of Oral & Maxillofacial Surgeons (CALAOMS).

I hereby make application for Resident Membership in the California Association of Oral & Maxillofacial Surgeons. If accepted, I will obey the Constitution, Bylaws and Pledge of the organization and will attend and contribute to the meetings whenever possible.

**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:** " \_\_\_\_\_ aaaa

**Children's Name(s) & Age** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_      **Place of Birth:** \_\_\_\_\_  
"City" "State/Country"

**Home Address:** \_\_\_\_\_  
" Street " Apt. #

" City " State " Zip

Telephone " 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
_____	_____
Year in Residency	Program Director
_____	
Expected Date of Graduation	

## 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:** \_\_\_\_\_

## Other states in which you are licensed to practice

_____	_____	_____
State	*****License Number	Date of Licensure
_____	_____	_____
State	*****License Number	Date of Licensure

Have you ever applied for Resident Membership to the California Association of Oral and Maxillofacial Surgeons prior to this application? Yes "No (If yes, date \_\_\_\_\_)

Are you a Resident Member of the American Association of Oral and Maxillofacial Surgeons? 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 Dental School training including all location of practice(s).** (Use separate sheet if necessary):

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**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.** (If applicable)

Present professional liability carrier	Amount of Coverage
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Policy Number	Expiration Date
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Prior professional Liability carrier
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Prior professional Liability carrier
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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 Surgeons. Your references may be instructors in your training program. 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

## Residents 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 Surgeons and, if I am elected to Resident 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 Resident 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.

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 Surgeons 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:** \_\_\_\_\_



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## 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 Surgeons (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 \_\_\_\_\_