CALIFORNIA ASSOCIATION of
ORAL & MAXILLOFACIAL SURGEONS

Advancing our specialty through ethics, education, public service and advocacy

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

950 RESERVE DRIVE, SUITE 120 ROSEVILLE, CA 95678 t 916.783.1332 f 916.772.9220 www.calaoms.org

CALIFORNIA ASSOCIATION of
ORAL & MAXILLOFACIAL SURGEONS

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Roseville, CA 95678
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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 **Social Security Number:** _____

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

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)**:**

_____

_____

_____

_____

_____

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

_____

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 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 _____