

**Chicago Society of Oral and Maxillofacial Surgeons**  
*An Illinois not-for-profit professional association*  
2258 Newport Lane, Geneva, IL 60134 / P: 630-408-4676 / F: 331-248-0555  
info@chicagosocietyofoms.org / www.chicagosocietyofoms.org

**Application for Membership**

**Contact Information**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Primary Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Please list other offices with address and phone and fax number on a separate sheet.

Email Address: \_\_\_\_\_

(Email is our primary form of communication. Please provide an email address that is monitored regularly.)

**History**

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Type of Practice:     Single     Partnership     Corporation     Association     Other

Pre-Dental College: \_\_\_\_\_ Location: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_ Degree: \_\_\_\_\_

Dental School: \_\_\_\_\_ Location: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_ Degree: \_\_\_\_\_

Location of Oral & Maxillofacial Internship: \_\_\_\_\_

Address: \_\_\_\_\_ Dates of Attendance: \_\_\_\_\_

Location of Oral & Maxillofacial Residency: \_\_\_\_\_

Address: \_\_\_\_\_ Dates of Attendance: \_\_\_\_\_

Additional Training: \_\_\_\_\_

**Licensure**

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?     Yes     No

Number of years: \_\_\_\_\_ Anesthesia Permit Number: \_\_\_\_\_

**References (Names and Addresses of two Members of CSOMS):**

\_\_\_\_\_  
\_\_\_\_\_

**Chicago Society of Oral and Maxillofacial Surgeons**

*An Illinois not-for-profit professional association*

2258 Newport Lane, Geneva, IL 60134 / P: 630-408-4676 / F: 331-248-0555

info@chicagosocietyofoms.org / www.chicagosocietyofoms.org

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

Membership in the following organizations is required for CSOMS membership. Please indicate membership in each:

AAOMS  ISOMS (or applicable State Society of OMS)

Other Dental or Medical Societies to which you belong: \_\_\_\_\_

Are you a diplomate of the American Board of Oral and Maxillofacial Surgery?  Yes  No Date: \_\_\_\_\_

Illinois State Board Specialty Number: \_\_\_\_\_

Do you teach any branch of Oral & Maxillofacial Surgery in a dental or medical school?  Yes  No

Name of School: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

Current Hospital Affiliation(s) Staff Memberships:

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ Position: \_\_\_\_\_

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ Position: \_\_\_\_\_

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ Position: \_\_\_\_\_

I hereby pledge, as a condition of membership in the Chicago Society of Oral and Maxillofacial Surgeons, to conduct myself with strict regard for the ethics of my profession; to place the welfare of my patients above all else; to endeavor constantly to advance in knowledge by study, interchange of thought and attendance at clinics and society meetings; to regard scrupulously the interest of my professional colleagues.

I understand that if I violate this pledge or do not live up to the Code of Professional Conduct and Official Advisory Opinion of the American Association of Oral and Maxillofacial Surgeons, charges against me shall be brought before the Executive Council and the Chicago Society of Oral and Maxillofacial Surgeons and I shall be liable to expulsion. I promise to return to the Society any Certificate of Membership if at any time I cease to be a member.

In consideration of CSOMS 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 CSOMS 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 returned to: CSOMS, 2258 Newport Lane, Geneva, IL 60134; or info@chicagosocietyofoms.org, along with dues payment of \$250.**

Payment method: Enclosed Check \_\_\_\_\_ Credit Card \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Exp.: \_\_\_\_\_ Security Code: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ E-mail: \_\_\_\_\_

\*\*\*\*\*

**Office Use Only:** Date Received: \_\_\_\_\_ Action by Executive Council: \_\_\_\_\_

Active  Associate  Honorary  Other \_\_\_\_\_

Action by CSOMS Membership: \_\_\_\_\_ Date: \_\_\_\_\_