CALIFORNIA ASSOCIATION of ORAL & MAXILLOFACIAL SURGEONS

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

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 _____

CALIFORNIA ASSOCIATION of
ORAL & MAXILLOFACIAL SURGEONS

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 **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

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: _____

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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_____

ORAL & FACIAL
SURGEONS of CALIFORNIA

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Roseville, CA 95678
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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 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 _____