Southeastern Society of Oral and Maxillofacial Surgeons

Application for Membership **Provisional Fee $275 _____**

NOTE: SEE INSTRUCTIONS FOR COMPLETING APPLICATION ON THE OTHER SIDE OF THIS FORM.

1. Full Name: _____ Degree: _____

2. Work address: _____Suite: _____ City: _____ State: _____ Zip: _____

   Office Practice Name (if applicable) : _____

3. Phone: _____ Fax: _____ E-mail: _____
   (By providing your fax number you grant SSOMS permission to fax information to you).

4. Name Preference: Applicant: _____ Spouse: _____

5. Date of Birth: mo/day/year: _____Place of Birth: _____

6. Pre-dental education: Name of University: _____

7. Dental school: _____

8. State in which you are presently licensed to practice: _____ License No.: _____

   Other state in which you are licensed to practice: _____

9. Postgraduate School (Give name of hospital, dates, years and degrees. Indicate if this was full-time appointment)
   Intern: _____ Residency: _____

10. Other graduate course(s): (optional)_____

11. Military duty: (Give rank, dates and professional experiences)

_____

12. Do you limit your practice to oral and maxillofacial surgery exclusively? Yes ☐ No ☐

13. For how long has your practice been limited to this specialty? _____

14. Are you a diplomate of the American Board of Oral and Maxillofacial Surgery? Yes ☐ No ☐ Date: _____

15. Do you teach any branch of oral surgery in a dental or medical school? _____

16. Name of School: _____ Position on faculty: _____

17. Present hospital affiliations (Give names of hospitals and positions on staff) _____

_____

18. Name dental and medical societies to which you belong: _____

19. Are you a member of the American Assoc. of Oral and Maxillofacial Surgeons* ? Yes ☐ No ☐
    * Required by bylaws. Please attach copy of certificate of membership or other proof.

20. List on a separate sheet an outline of your major contributions to scientific literature. (optional)

I hereby certify that the information in this application and the accompanying forms is accurate. I hereby make application for membership in the SOUTHEASERN SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS. If accepted, I agree to obey the Constitution and Bylaws, of said Society. I agree that upon membership into the Society, the membership certificate will remain the property of the Society and will be returned when I am no longer a member or upon justifiable request. I authorize SSOMS to contact any source necessary to verify the facts presented on this application. This application becomes a part of the permanent records of the Society.

Signature: _____ Date: _____

"Contributions or gifts to this Association are not deductible as charitable contributions for federal income tax purposes. Dues payments are deductible by members as ordinary and necessary business expense."

Please return to: **SSOMS**
4850 Golden Parkway, Suite 418-B
Buford, Georgia 30518
Phone:770/271-0453 Fax: 770/271-0634

Southeastern Society of Oral and Maxillofacial Surgeons
MEMBERSHIP REQUIREMENTS

ACTIVE:

- Dentists who limit their practice to the specialty of Oral and Maxillofacial Surgery and are practicing in one of the following states: AL, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV, and PR or hold a full-time teaching position in Oral and Maxillofacial Surgery in one of the dental colleges in these same states.
- Dentists who are members of AAOMS.
- Oral and Maxillofacial Surgeons who have practiced in either the Veterans Administration, U.S. Public Health Service, or any branch of the Armed Forces for at least three (3) years immediately preceding the application for membership. The applicants, if not a Diplomate of the ABOMS, shall submit a signed and certified letter from the Chief of the Dental Corps of the respective branch of the government service in which he serves which shall state that the applicant's military occupational specialty number not only in "oral and maxillofacial surgery" in the personnel records of the service in Washington, D.C., but that his duties have been limited to this specialty. Applicants from government services must hold a license to practice in one of the states listed above.

ASSOCIATE MEMBERSHIP:

Same as above except applicant's practice is located in a state other than those listed above.

INSTRUCTIONS FOR COMPLETING APPLICATION

1. **Complete application form:**
   - Fill in name of two sponsors. If applying for active membership, at least one sponsor must be from the state where the applicant practices.
2. **Attach the following:**
   - Check for $275.00 for provisional dues.
3. **Dues:**
   - Once approved for membership, your provisional dues will be counted for your first year's dues and then you will be billed the following year and annually for dues of $275.

*ALL **CANDIDATES** MUST BE **INTERVIEWED IN PERSON** BY THE CREDENTIALS & MEMBERSHIP COMMITTEE WITHIN THREE (3) YEARS OF THE DATE OF COMPLETION OF THE APPLICATION. THE COMMITTEE INTERVIEWS CANDIDATES ON THE FIRST DAY OF EACH ANNUAL MEETING.*