SOUTH CAROLINA SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

NOTICE TO APPLICANTS:

MEMBERSHIP SHALL CONSIST OF DENTISTS WHO LIMIT THEIR PRACTICE TO ORAL AND MAXILLOFACIAL SURGERY. AN APPLICANT IS ELIGIBLE TO FILE APPLICATION AFTER HIS OR HER FINAL YEAR OF APPROVED TRAINING IN ORAL AND MAXILLOFACIAL SURGERY.

DATE: _____

1. FULL NAME _____ U.S. CITIZEN _____YES _____ NO
   LAST FIRST MIDDLE

2. OFFICE ADDRESS _____
   STREET CITY STATE ZIP PHONE

   HOME ADDRESS _____
   STREET CITY STATE ZIP PHONE

3. DATE AND PLACE OF BIRTH _____
   MONTH DAY YEAR CITY STATE

4. EDUCATION:

   PRE-DENTAL _____
   NAME OF COLLEGE/UNIVERSITY DATE OF GRADUATION DEGREE

   DENTAL _____
   NAME OF SCHOOL DATE OF GRADUATION DEGREE

5. ADVANCED EDUCATION IN ORAL AND MAXILLOFACIAL SURGERY

   FROM _____ TO _____

   _____
   NAME OF INSTITUTION CITY STATE

   _____
   NAME OF DIRECTOR OF ORAL AND MAXILLOFACIAL SURGERY

6. ADDITIONAL COURSES AND DEGREES, IF ANY _____

   _____

   _____

7. Are you licensed in the state of South Carolina? Dental: _____ YES _____ NO; Medical: _____ YES _____ NO

8. Do you have an oral and maxillofacial surgery specialty license in South Carolina? _____ YES _____ NO

9. MILITARY DUTY (RANK, PROFESSIONAL EXPERIENCE AND INCLUSIVE DATES) _____

   _____

10. Is your practice limited exclusively to oral and maxillofacial surgery? _____ YES _____ NO

11. Are you a diplomate of the American Board of Oral and Maxillofacial Surgery? _____ YES _____ NO

    DATE: _____

12. Are you engaged in Research or training of Oral and Maxillofacial Surgery in a dental or medical institution?

_____ YES _____ NO _____
NAME OF INSTITUTION

_____
YOUR FACULTY POSITION DATE OF APPOINTMENT

13. Are you a member of A.A.O.M.S.? _____ YES _____ NO

If yes, what type of membership? _____

14. Have you previously applied for membership in S.C.S.O.M.S and if so, when? _____

15. Have you ever had a professional license revoked or suspended? _____ YES _____ NO

16. Have you ever had hospital privileges denied, revoked or suspended? _____ YES _____ NO

17. Have you ever been convicted or a felony? _____ YES _____ NO

18. Have you ever lost or settled a malpractice lawsuit? _____ YES _____ NO

If you answered YES to questions 15 – 18, please explain below:

_____

_____

_____

_____

_____

_____

DECLARATION:

I will abide by the code of professional conduct and official advisory opinions of the A.A.O.M.S.

_____
YOUR SIGNATURE

THE CREDENTIALS COMMITTEE ON MEMBERSHIP, IN PRELIMINARILY EVALUATING YOUR APPLICATION, REQUIRES THE NAMES AND COMPLETE ADDRESSES OF AT LEAST THREE CURRENT FELLOWS OF THE AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS FOR REFERENCES, EXCLUSIVE OF THE CHIEF OF YOUR ORAL SURGERY TRAINING PROGRAM. **AT LEAST ONE OF THESE REFERENCES SHOULD BE A MEMBER OF THE SOUTH CAROLINA SOCIETY OF ORAL & MAXILLOFACIAL SURGEONS.**

_____ YEARS KNOWN _____
NAME

_____
STREET

_____

CITY STATE ZIP

_____ YEARS KNOWN_____
NAME

_____
STREET

_____
CITY STATE ZIP

_____ YEARS KNOWN_____
NAME

_____
STREET

_____
CITY STATE
