Indiana Society of Oral and Maxillofacial Surgeons

Dear Doctor:

Thank you for your interest in becoming a member of the Indiana Society of Oral and Maxillofacial Surgeons.

After you have filled out the application form and obtained your two letters of recommendation from ACTIVE Indiana Society members, please forward those documents along with your CV and check in the amount of $180.00 to the address listed at the bottom of this letter.

Once your application has been received and verified that it is complete, it will be presented to the ISOMS Board of Directors and the Membership at our next annual meeting, which is normally held in February or March each year.

If you have any questions regarding this process or about becoming a member of the ISOMS, please do not hesitate to contact me.

Sincerely,

Laney Dezelan
ISOMS Executive Secretary
isoms4489@gmail.com
317-577-4489

Please remit to: ISOMS
11307 Reflection Point Drive
Fishers, IN 46037

**INDIANA SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS**

**SOCIETY OBJECTIVES**

**To contribute to the health and welfare of the public**

**To promote the science and art of Oral and Maxillofacial Surgery**

**To cooperate with other health services**

**To enlighten the general public concerning the specialty of Oral and Maxillofacial Surgery**

**To provide among its members the opportunity for social and professional fellowship**

**To promote and provide continuing education for the Oral and Maxillofacial Surgeon**

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**APPLICATION FOR MEMBERSHIP**

(Please type or print legibly)

Name_____
(as you wish it to appear on certificate)

Office Address_____
Street City/State/Zip

Office Phone_____ *Office Fax_____

E-Mail Address_____

Home Address_____
Street City/State/Zip

Spouse_____ Home Phone_____ Cell Phone_____

Graduate/Post-Graduate Study:

Institution_____

Dates_____ Head of Dept._____

Degree(s)_____

Internship/Residency:

Institution_____

Dates_____ Head of Dept._____

Institution_____

Dates_____ Head of Dept._____

Military Experience:

Dates_____

Rank_____

Teaching Experience:

Institution_____

Title_____

Year_____

Hospital Staff Appointments:

_____

_____

Membership in AAOMS (check one):

Non-member _____ Applicant _____ Associate _____

Candidate _____ Active _____

Diplomate American Board of Oral and Maxillofacial Surgery:

Year Certified _____ (If scheduled for examination, check here _____)

Other professional organizations you belong to: (if you require additional space, please use back of form)

_____

_____

_____

I have been in the exclusive practice of Oral and Maxillofacial Surgery (not including internship and residency) from _____ to _____.

I hereby certify that the above information is correct to the best of my knowledge, and if accepted for membership in the Indiana Society of Oral and Maxillofacial Surgeons, will pursue my calling with strict regard for the ethics of my profession and strive to further the Society's objectives to the fullest of my capabilities.

_____ _____

Printed Name Signature

_____

***Sponsored and Endorsed by:** Date

(Please print name)

1. _____ Active ISOMS Member
2. _____ Active ISOMS Member

***Letter of Recommendation must be included from each sponsor.**

**Enclose application fee of $180.00**
**Enclose Curriculum Vitae**

**RETURN TO: Laney Dezelan, Executive Secretary**
**ISOMS**
**11307 Reflection Point Drive**
**Fishers, IN 46037**
**(317) 577-4489**