



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 \_\_\_\_\_

**Required** E-Mail Address \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City/State/Zip

Spouse Name \_\_\_\_\_ 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:**

(Please print name)

\_\_\_\_\_  
Date

1. \_\_\_\_\_ Active ISOMS Member

2. \_\_\_\_\_ Active ISOMS Member

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

**Enclose application fee of \$600.00**  
**Enclose Curriculum Vitae**

**RETURN TO: Laney Dezelan, Executive Secretary**  
**ISOMS**  
**11307 Reflection Point Drive**  
**Fishers, IN 46037**  
**(317) 409-9330**