



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 \$600.00 to the address listed at the bottom of this letter. (Annual dues will be \$500.00 thereafter.)

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 Director
isoms4489@gmail.com
317-409-9330
Please remit to:

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

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**