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 $500.00 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 Director
isoms4489@gmail.com
317-409-9330

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)

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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

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***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 $500.00
Enclose Curriculum Vitae

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