



**INTERNATIONAL ASSOCIATION OF
ORAL AND MAXILLOFACIAL SURGEONS**

Application to Become a Fellow Member of the IAOMS

Executive Director Approval: _____

Receipt of Fellowship Fee: _____

Membership Number: _____

Notification of Acceptance: _____

Shanghai, Peoples Republic of China

19th ICOMS 2009

Personal Information (all * marked fields are mandatory)

Last Name * _____

First Name * _____ Middle Name _____

Birthday * _____

Email Address * _____

Communication Preference * Email Postal **Mailing Address:** Home Office

Street * _____

Street _____

City * _____

State _____ Postal Code: _____

Country * _____

Office (Country Code/Area Code/Number)

Home (Country Code/Area Code/Number)

Telephone # * _____ / _____ / _____

Fax # _____ / _____ / _____

Mobile # _____ / _____ / _____

Training and Qualification Information

Name of OMS Training Program * _____

Date Training Program Completed * _____

Degree(s) Check all that apply * DDS/DMD or equivalent Master's Degree

MD/MBBS or equivalent Ph.D

Professional Information (all * marked fields are mandatory)

OMS Membership

Are you a member of your national association or society of oral and maxillofacial surgeons? * Yes No

Please list names of the Association or Society *

Are you a member of your regional association or society of oral and maxillofacial surgeons? * Yes No

Please list name(s) of the Association or Society *

Practices

Do you exclusively practice oral and maxillofacial surgery? * Yes No

Dentistry Medicine Other _____

Return Form to: Ms. Lynne Saylor
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Oakbrook Terrace, IL 60801 U.S.A.

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Email: lsaylor@iaoms.org