



North Carolina Society of Oral & Maxillofacial Surgeons

Membership Application

Please complete the following application, submit with your state anesthesia evaluation and your application fee of \$150.00 made payable to NCSOMS. A recommendation by an Oral & Maxillofacial Surgeon should be mailed directly to the North Carolina Society of Oral & Maxillofacial Surgeons office. Questions may be directed to 919.418.1325 or nc-oms@bluestarservices.net. All information is to be submitted to:

North Carolina Society of Oral & Maxillofacial Surgeons
c/o Blue Star Services
1829 East Franklin Street, Suite 600
Chapel Hill, NC 27514

Personal Information

First Name

Middle Name

Last Name

Degree

Citizenship

Date of Birth

Country of Birth

Address Information

Mailing Address

Company/Organization Name

Address 1

Address 2

City

State

Zip Code

Phone Number

FAX Number

E-mail Address

Education

Dental

Beginning Date

Graduation Date

Degree

Name of College or University

City

State

Zip Code

Country

Medical
Beginning Date

Graduation Date

Degree

Name of College or University

City

State

Zip Code

Country

Postgraduate Training

OMS Residency
Beginning Date

Completion Date

Name of OMS Director

Name of Institution

City

State

Zip Code

Country

Fellowship/ Other Postgraduate

Beginning Date

Completion Date

Name of Institution

City

State

Zip Code

Country

Additional Information

1. Are you a Diplomat of the ABOMS? ___No ___Yes Year _____
2. Have you ever been denied a dental, OMS or medical license? ___No ___Yes
3. Have you ever had a dental, OMS or medical license suspended or revoked? ___No ___Yes
4. Have you ever been convicted of a felony? ___No ___Yes
5. Have you ever been subject to any liability, judgment or credentialing action that has been or has the potential for being reported to the National Practitioner Data Bank (NPDB)? ___No ___Yes

If you answered yes to 2 -5? Please explain _____

6. Present type of practice:

- _____ Currently a Resident
- _____ Private Practice
- _____ Full-time Faculty
- _____ Federal Service

Branch of Service _____ Rank _____ Grade

____ Veterans Administration Grade Level _____

____ Public Health Services Grade Level _____

7. Dental and Medical Society and Association Memberships

____ American Dental Association Year Joined _____

____ American Medical Association Year Joined _____

8. Have you ever been subject to any liability, judgment or credentialing action that has been or has the potential for being reported to the National Practitioner Data Bank (NPDB)?

If yes, please explain

Declaration

I hereby pledge myself, as a condition of Membership in the North Carolina Society of Oral and Maxillofacial Surgeons, to pursue my calling with strict regard for the ethics of my profession; to place the welfare of my patients above all else; to endeavor constantly to advance in knowledge by study, interchange of thought; and attendance at clinics and association meetings; to regard scrupulously the interests of my professional colleagues and render willing help to them. It is understood that if I violate this pledge or do not live up to the code of professional conduct, my name will be dropped automatically, or I may be subjected to disciplinary action or subject to expulsion. I understand that this application and all supporting documents remain the property of the association.

I understand that the certificate of membership remains the property of the society and must be returned when requested. In addition, for and in consideration of the agreement of the Association to consider my application as foresaid, I hereby and herewith waive any right to any actions at law or equity which might otherwise arise out of any rejection by the Society. I, the undersigned, state that each of the matters and things set forth by me in the above foregoing application is true in substance and in fact; and I understand that each of the matters and things above the set forth by me are material representations upon which the North Carolina Society of Oral and Maxillofacial Surgeons is entitled in evaluation of this application.

Signature

Date

For office use only

Application Date Received _____

Recommendation Date Received _____

Anesthesia Evaluation Date Received _____

Application Fee Date Received _____ Check # _____ Amount _____