NYSS OMS
NEW YORK STATE SOCIETY *of* Oral and Maxillofacial Surgeons

New York State of Oral & Maxillofacial Surgeons
20 Corporate Woods Boulevard, Suite 602,
Albany, New York 12211

Phone: 800.255.2100 | Fax: 518.465.3219
Email: info@nysdental.org
Web: www.nyssoms.org

APPLICATION FOR MEMBERSHIP

Please type or print clearly.

First Middle Last, Suffix Degree(s)

Citizenship: ☐ I am a U.S. citizen. ☐ Other _____

ADDRESS INFORMATION

Preferred Mailing Address: ☐ Office ☐ Home

Company Name

Office Address Suite/Floor City State ZIP Code

Office Phone Fax Work Email

Home Address Apartment/Unit City State ZIP Code

Home Phone Cell Personal Email

EDUCATION *Include month and year*

Dental

Beginning Date Graduation Date Degree

Name of College or University City State

Medical

Beginning Date Graduation Date Degree

Name of College or University City State

POSTGRADUATE TRAINING *Include month and year*

OMS Residency

_____

Start Date | Completion Date | Name of OMS Director

_____

Name of Institution | City | State | Country

Fellowship

_____

Start Date | Completion Date

_____

Name of Institution | City | State | Country

Other Postgraduate

_____

Start Date | Completion Date | Area of Study

_____

Name of Institution | City | State | Country

PROFESSIONAL AFFILIATIONS

1. Are you a Diplomate of ABOMS?

☐ No ☐ Yes: Year _____

2. Present type of practice

☐ Currently a resident

☐ Group practice – total in group _____

☐ Veterans Affairs

☐ Federal Service (active duty Army, Navy, Air Force)

☐ Full-time faculty, OMS program:

Program Name _____ Program Director _____

☐ Solo practice

☐ Dental Support Organization (DSO)

☐ Public Health Service

☐ Full-time Faculty, non-OMS program:

3. Dental and Medical Society and Association Memberships

☐ American Dental Association Year joined _____

☐ American Medical Association Year joined _____

☐ Other _____ Year joined _____

ADDITIONAL INFORMATION *Use a separate sheet if necessary.*

4. Have you ever been denied a dental, OMS or medical license?

☐ No ☐ Yes *In what state? Please explain and provide documentation.*

_____

5. Have you ever had a dental, OMS or medical license suspended or revoked?

☐ No ☐ Yes *In what state? Please explain and provide documentation.*

_____

6. Have you ever been convicted of a felony? *Note: A felony conviction will not automatically bar membership.*

☐ No ☐ Yes *Please explain and provide documentation.*

_____

7. States in which you are licensed to practice and dates of licensure and license number(s): _____

8. Is your practice limited exclusively to oral surgery? ☐ No ☐ Yes For how long? _____

9. Present hospital affiliations (state date of appointment and position): _____

_____

_____

Demographics *For statistical purposes only.*

☐ *American Indian*
☐ *Asian*
☐ *Black/African American*
☐ *East Indian*
☐ *Hispanic*
☐ *Middle Eastern/North African*
☐ *Multi-ethnic/Multiracial*
☐ *Native Hawaiian/Other Pacific Islander*
☐ *White/Caucasian*
☐ *Other* _____
☐ *Prefer Not to Answer*

AAOMS MEMBERSHIP CONSENT AGREEMENT

☐ Membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) is a requirement of NYSSOMS membership. By marking the checkbox, you are providing consent for NYSSOMS to share your membership information with AAOMS.

DECLARATION

I hereby pledge myself, as a condition of membership in the New York State 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 AAOMS 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 Society.

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 Society to consider my application as fore said, 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 set forth by me are material representations upon which the New York State Society of Oral and Maxillofacial Surgeons is entitled to in evaluation of this application.

Applicant Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND WAIVER OF LIABILITY

By applying for Fellowship or membership to the New York State Society of Oral and Maxillofacial Surgeons (hereafter referred to as the"Society"), I agree to the following conditions during the processing and consideration of my application, regardless of whether or not I am elected to membership:

1. **Authorization for Release of Information to the Society by Third Parties**
   By my signature below, I authorize the release of otherwise confidential information to the Society and its authorized representatives by sources such as official licensing or regulatory agencies, professional associations, hospitals or other healthcare organizations, educational institutions or other relevant sources.
2. **Waiver of Liability**
   I extend immunity to, and release from any liability, the Society and its authorized representatives for any acts, communications or decisions regarding the processing, consideration and maintenance of my membership application and file.
3. **Acknowledgement of Society Governing Rules and Regulations**
   I acknowledge that my membership status in the Society is based on its Bylaws as well as the Governing Rules and Regulations of AAOMS. I agree to abide by these governing documents and I recognize the Society has the right to limit or terminate my membership status under its Bylaws or the Code of Professional Conduct of AAOMS.

Applicant Signature _____ Date _____

COMPLETED FORM IS TO BE RETURNED BY RESPONDENT TO:

Isabella Ayala
i.ayala@nysdental.org

NYSSOMS
20 Corporate Woods Blvd. #60
ALBANY, NY 12211

Once completed, please email to Isabella Ayala at iayala@nysdental.org.
If you have any questions, call Isabella at 800-255-2100.

For Administrative Use Only

ID Date Received