INTERNATIONAL ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

CONFIRMATION OF TRAINEE STATUS FOR IAOMS MEMBERSHIP

APPLICANT INFORMATION		
Name of Applicant for IAOMS Membership:		
Primary Address:		
City:	State:	Postal Code:
Country:	Primary Phone Number:	
Email Address:	Fax:	

TO BE COMPLETED BY PROGRAM DIRECTOR	
This is to confirm that the above named candidate for membership to the International Association of Oral and Maxillofacial Surgeons is enrolled in the oral and maxillofacial training program at our institute. Sub-specialty programs are not applicable.	
Name of OMS Training Program:	
Address:	
Anticipated Completion Date:	
Additional Comments:	
Program Director-Print Name:	
Program Director Signature:	
Date	
Address:	
City:	State:
Postal Code:	Country:
Email Address:	Fax:

RETURN CONFIRMATION AND APPLICATION TO:

Katie Cairns, Membership Manager
IAOMS
8618 W. Catalpa Ave., Suite 1116
Chicago, IL 60656 U.S.A.
Telephone: 1.224.232.8737
Fax:1.224.735.2965
E-Mail: kcairns@iaoms.org