



Membership Application
Washington State Society of Oral and Maxillofacial Surgeons

1. Full Name _____ Degree(s) _____

Social Security Number: _____

2. Office Address _____

City _____ State _____ Zipcode _____

Telephone (____) _____ Fax (____) _____

Email _____

3. Home Address _____

City _____ State _____ Zipcode _____

Telephone(____) _____

4. Date of Birth _____ Place of Birth _____

5. Education

Pre-Dental _____ Graduation Date _____ Degree _____

Dental _____ Graduation Date _____ Degree _____

8040 161st Avenue NE, #244, Redmond, WA 98052

(206) 419-8672 FAX (425) 487-9607

www.wssoms.com email: wssoms@gmail.com

Oral Surgery Internship: Place_____

Dates_____

Oral Surgery Residency: Place_____

Dates_____

6. Additional Courses, Postgraduate Studies, Fellowships, Etc.

7. Military Duty

Branch of Service_____Discharge Status_____

Highest Rank Obtained_____Dates of Service_____

8. States and Provinces in Which You Are Licensed to Practice Dentistry (Oral Surgery)

State_____License Number_____Date Licensed_____

State_____License Number_____Date Licensed_____

State_____License Number_____Date Licensed_____

9. Hospital Affiliations:

Name_____Date of Appointment_____

Name_____Date of Appointment_____

9. Are you a member of the American Dental Association?_____

10. Are you a member of the American Association of Oral and Maxillofacial Surgeons?_____

11. Are you a Diplomate of the American Board of Oral Surgery?_____

12. List any other professional memberships: _____

13. Is your practice limited exclusively to oral and maxillofacial surgery? _____

14. Are you a member of a group practice? If yes, name of partners in the office.

15. The signatures of two members of the Washington State Society of Oral and Maxillofacial Surgeons as endorsement to your membership are required.

Signature and Printed Name _____

Signature and Printed Name _____

16. Declaration: I hereby pledge myself as a member of the Washington State Society of Oral and Maxillofacial Surgeons (WSSOMS) 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 Society meetings; to regard scrupulously the interests of my professional brothers and sisters and render willing help to my colleagues.

Your signature _____ Date _____

Please mail your application along with a check for \$400 for your first dues payment to the WSSOMS office, 8040 161 Avenue NE, #244, Redmond, WA 98052. Please note that \$150 of your dues is NOT deductible as a business expense because it relates to WSSOMS lobbying and political expenditures.

For WSSOMS use only

Application received _____

First reading at business meeting _____

Second reading at business meeting _____

Membership letter sent _____