WSSOMS

WASHINGTON STATE SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

Membership Application
Washington State Society of Oral and Maxillofacial Surgeons

1. Full Name_____ Degree(s)_____

2. Office Address_____

City_____State_____Zipcode_____

Telephone (____)_____

Email_____

3. Practice Name_____

Practice Website_____

4. Home Address_____

City_____State_____Zipcode_____

Telephone (____)_____

5. Date of Birth_____Place of Birth_____

6. Education

Pre-Dental_____Graduation Date_____Degree____

Dental_____Graduation Date_____Degree____

8151 164th 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_____

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

_____

_____

_____

8. Military Duty

Branch of Service_____Discharge Status_____

Highest Rank Obtained_____Dates of Service_____

9. 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_____

10. Hospital Affiliations:

Name_____Date of Appointment_____

Name_____Date of Appointment_____

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

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

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

14. List any other professional memberships: _____

_____

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

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

_____

17. 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_____

18. 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 $550 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_____