



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, 8151 164 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 _____