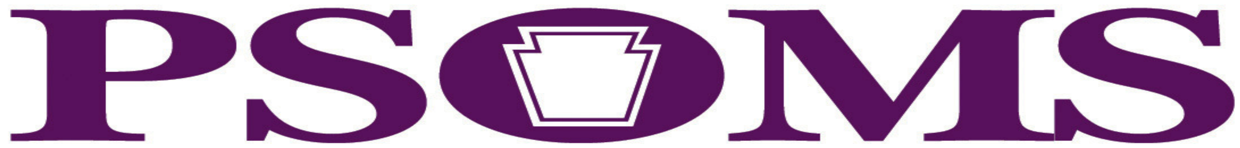

PSOMS

Post Office Box 500 · Harrisburg, PA 17057
1-877-PSOMS-78 · 717-939-7900 fax · www.psomsweb.org

WELCOME

We are pleased that you are considering membership in the Pennsylvania Society of Oral and Maxillofacial Surgeons! Our application and supporting documents can be found on our website, *www.psomsweb.org* or can be mailed to you upon request. Please refer to the *Applicant Checklist* to ensure that your application is complete as this will help speed the application process. Your application, supporting documents and *non-refundable* payment of $300 should be sent to the following address:

Pennsylvania Society of Oral and Maxillofacial Surgeons
c/o Christine Corrigan
PO Box 500
Harrisburg, Pa 17108-0500

Upon receipt, your application will be presented to the Membership Committee for verification of credentials including a search of the National Practitioner Data Bank (NPDB). Additionally, you will be contacted by your region's liaison of our Welcoming Committee to schedule an interview. The purpose of this interview is to further familiarize you with the Society and the **Office Anesthesia Evaluation Program.** Following such, your application will undergo final review by the Membership Committee. If approved, you will be presented at our spring meeting for introduction into the Society.

The Society hosts one formal meeting each year, usually held in the spring. We welcome your attendance and encourage participation.

Should you have any questions regarding the application process, please contact **Christine Corrigan**, Executive Secretary of PSOMS, at info@psomsweb.org or call (877) PSOMS-78
We look forward to your active participation in the Pennsylvania Society of Oral and Maxillofacial Surgeons.

Thank you for your interest!

Pennsylvania Society of
Oral & Maxillofacial Surgeons

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PSOMS APPLICATION CHECKLIST

We are pleased you are considering membership in the Pennsylvania Society of Oral and Maxillofacial Surgeons! Below is a check list of essential documents required to complete the application process.

- ✓ Completed and signed application
- ✓ Copy of oral and maxillofacial residency training certificate
- ✓ Copy of all current *dental* and/or *medical* licenses
- ✓ If applicable, copy of ABOMS board certificate
- ✓ If applicable, copy of fellowship training certificate
- ✓ If applicable, document with detailed explanation of any affirmative answers to questions 7-11 on page 3 of 3 of PSOMS application.
- ✓ Signed Applicant Statement
- ✓ Signed Release of Information and Waiver of Liability
- ✓ *Non-refundable* payment of **$300** made payable to “PSOMS”

Send application, supporting documents and *non-refundable* payment to:

Pennsylvania Society of Oral and Maxillofacial Surgeons
c/o Christine Corrigan
PO Box 500
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Questions may be directed to **Christine Corrigan**, Executive Secretary PSOMS, at info@psomsweb.org or (877) PSOMS-78

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APPLICANT STATEMENT

I certify that I have never been disciplined, sanctioned, expelled or refused membership in a dental, medical or other professional society or healthcare related organization, hospital, etc. except as explained in my application.

I certify that I will abide by the Constitution and Bylaws of the Pennsylvania Society of Oral and Maxillofacial Surgeons (hereafter referred to as the "Association") if I am granted membership. I agree that my membership in this organization shall be conditioned upon my compliance with the Constitution, Bylaws and the professional ethics of the Association as well as, the Constitution, Bylaws and professional ethics of the American Association of Oral and Maxillofacial Surgeons.

I further agree that I will recognize the authorized officers of the Association as the proper authorities to interpret any doubtful points of professional ethics and will at all times abide by and be governed by their interpretations.

I understand and acknowledge that membership to the Association is a privilege conferred upon a candidate, and that the organization is in no way obligated to approve any application or to explain its action of approval or disapproval. The organization has no obligation to return application fees if membership is not granted. Additionally, I herewith waive any right to any actions at law or equity which might otherwise arise out of any rejection by the Association.

I understand any information submitted in this application and any additional information may be verified. Additionally, I understand that my application and all supporting documents remain the property of the Association. *I understand that the certificate of membership remains the property of the Association and must be returned when requested.*

I hereby authorize the Association to make known to hospitals, professional societies and associations and any other healthcare related organizations any information the Association may have concerning me.

Name of Applicant (Type or Print): ____

Signature: ________________________________ **Date:** _____________

PENNSYLVANIA SOCIETY OF
ORAL & MAXILLOFACIAL SURGEONS
PSOMS

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PENNSYLVANIA SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS APPLICATION FOR MEMBERSHIP

PERSONAL INFORMATION O Male O Female

Name: ____
First Middle Last Degrees

Date of Birth: ___________ **Place of Birth:** _________________ **Citizenship:** ____________

ADDRESS INFORMATION

Preferred Mailing Address: O Office O Home

Primary Office Address

____
____
____
____

Phone #: (____)______________________

Business e-mail:

____

Home Address

____
____
____
____

Phone #: (____)______________________

Home e-mail:

____

EDUCATIONAL INFORMATION

Dental School

____

Dates of Attendance
Start: ______________________
Graduation: ______________________

Medical School

____

Dates of Attendance
Start: ______________________
Graduation: ______________________

POST GRADUATE OMS TRAINING

OMS Residency: ____
Name of Institution: ____
Start Date: _________________ **Completion Date:** _________________
Address

____
____
____
____

Phone #: (____)______________________

Name of Current OMS Director: ____________________

FELLOWSHIP TRAINING

Name of Fellowship: ____________________
Name of Institution: ____________________
Start Date: ____________ **Completion Date:** ____________
Address

____
____
____
____

Phone #: (   ) ____________________

Name of Current Fellowship Director: ____________________

OTHER POSTGRADUATE TRAINING

Area of Study / Training: ____________________
Name of Institution: ____________________
Start Date: ____________ **Completion Date:** ____________
Address

____
____
____
____

Phone #: (   ) ____________________ **Email:** ____________________

Name of Current Director: ____________________

HOSPITAL STAFF APPOINTMENTS

____________________	____________________
Name of institution	**Name of institution**
____________________	____________________
City and State	**City and State**
____________________	____________________
Name of institution	**Name of institution**
____________________	____________________
City and State	**City and State**

OTHER PROFESSIONAL SOCIETY MEMBERSHIPS

Please indicate leadership roles, if any

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

1. Do you have a current PA dental license? **O** Yes - please submit copy **O** No
2. Do you have a current PA medical license? **O** Yes - please submit copy **O** No
3. Are you a member of ADA? **O** Yes - ADA number: ____________________ **O** No

4. Are you a member of AAOMS? **O** Yes **O** Application in Progress **O** No

5. Are you a Diplomate of ABOMS? **O** Yes - Year Certified: _____________ **O** No

6. Do you have a dental or medical license for any state other than Pennsylvania **O** No

O Yes - Please list each state and *submit corresponding copy of each license*

____

____

____

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE SUBMIT A DETAILED EXPLANATION ON A SEPARATE SHEET

7. Has your license to practice in any jurisdiction ever been limited, suspended, revoked, denied or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted?

O Yes **O** No

8. Has your Drug Enforcement Agency Permit for dispensing controlled substances ever been denied, revoked, suspended or not renewed or have proceedings toward those ends ever been instituted?

O Yes **O** No

9. Have you ever voluntarily relinquished a medical staff membership, a clinical privilege, a professional license, or narcotics registration under threat of disciplinary action? **O** Yes **O** No

10. Is any professional liability litigation pending against you? **O** Yes **O** No

11. Have you ever been convicted of a felony or is any criminal litigation pending against you?

O Yes **O** No

REFERENCES

Please obtain two sponsors of endorsement from members of this society.

Sponsor: ____
Name Phone number or e-mail address

Sponsor: ____
Name Phone number or e-mail address

Note: When you become a member, you are entitled to a PSOMS membership certificate.
Please print or type your name exactly as you wish it to appear on your certificate.

Printed or typed name: ______________________________________
(Be specific with regards to degree, middle initial, etc.)

SIGNATURE: ________________________________ **DATE:** ______________

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AUTHORIZATION OF RELEASE OF INFORMATION AND WAIVER OF LIABILITY

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

1. Authorization for Release of Information to the Association by Third Parties
By my signature below, I authorize the release of otherwise confidential information to the Association and its authorized representatives by sources such as official licensing or regulatory agencies, professional associations, hospitals or other health care organizations, educational institutions, or other relevant sources.

2. Waiver of Liability
I extend immunity to, and release from any liability, the Association 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 Association Governing Rules and Regulations
I acknowledge that my membership status in the Association is based on the Association's Governing Rules and Regulations. I agree to abide by the provisions of the Governing Rules and Regulations and I recognize that the Association has the right to limit or terminate my membership status under the Association's Constitution, Bylaws or American Association of Oral and Maxillofacial Surgeon's Code of Professional Conduct.

Name of Applicant (Type or Print): ____

Signature: ________________________________ **Date:** _____________