



AMERICAN SOCIETY OF MAXILLOFACIAL SURGEONS®

APPLICATION FOR MEMBERSHIP

This application must be typed or printed in detail and returned to the ASMS Office with the application fee of \$50.00 (US Dollars). Applicants successfully elected into membership will be notified in writing by the ASMS Office.

PLEASE INDICATE THE MEMBERSHIP YOU ARE APPLYING FOR (CHECK ONE ONLY):

- Active Membership** **Associate Membership**

Print or Type Reference Name: _____

(Must be either Active or Senior ASMS Member)

Print or Type Sponsor Name: _____

(Must be either Active or Senior ASMS Member)

- International Membership** **Print or Type Sponsor Name:** _____

(Must be either Active or Senior ASMS Member)

- Candidate for Membership** *(please provide sponsor signature below)*

Print or Type Sponsor Name: _____

(Must be either Active or Senior ASMS Member)

Signature: _____

APPLICATION INFORMATION

Full Name: _____ **Spouse Name:** _____

Company/Institution Name: _____

Company/Institution Address: _____

City, State & Zip Code: _____

Telephone: _____ **Fax:** _____

Email: _____

Home Address: _____

City, State & Zip Code: _____

Telephone: _____ **Fax:** _____

Email: _____

Age: ____ **Date of Birth:** _____ **Place of Birth:** _____ **Citizen of:** _____

EDUCATION

Pre-Medical Education: _____

Degree: _____ **Dates:** _____

Medical Education: _____

Degree: _____ **Dates:** _____

Dental Education: _____

Degree: _____ **Dates:** _____

Internship (type of service): _____

Dates: _____

RESIDENCIES (Hospital, Locations)

General Surgery: _____ **Dates:** _____

Plastic Surgery: _____ **Dates:** _____

Internship (type of service): _____ **Dates:** _____

OTHER POST GRADUATE TRAINING

Location: _____ **Position Held:** _____

Dates: _____

Location: _____ **Position Held:** _____

Dates: _____

Location: _____ **Position Held:** _____

Dates: _____

Location: _____ **Position Held:** _____

Dates: _____

ADDITIONAL TRAINING

Have you had experience in the following areas in the last 12 months? (Please check appropriate boxes)

- | | | |
|---|--|--|
| <input type="checkbox"/> Facial fractures | <input type="checkbox"/> Orthognathic surgery | <input type="checkbox"/> Cleft lip and palate |
| <input type="checkbox"/> Head and neck reconstruction | <input type="checkbox"/> Congenital facial deformities | <input type="checkbox"/> Cosmetic facial surgery |
| <input type="checkbox"/> Post traumatic skeletal and soft tissue reconstruction | | |

BOARD CERTIFICATIONS (Candidate for Membership indicate eligible date)

Plastic Surgery: _____ Dates: _____

Other: _____ Dates: _____

Other: _____ Dates: _____

Other: _____ Dates: _____

EXPERIENCE (Hospital Staff Appointments/Locations)

Hospital: _____

City & State: _____ Dates: _____

Hospital: _____

City & State: _____ Dates: _____

Hospital: _____

City & State: _____ Dates: _____

Hospital: _____

City & State: _____ Dates: _____

Military Experience: _____

City & State: _____ Dates: _____

Military Experience: _____

City & State: _____ Dates: _____

Teaching Positions: _____

City & State: _____ Dates: _____

Teaching Positions: _____

City & State: _____ Dates: _____

Special Training in Maxillofacial Surgery, etc.: _____

Years in Practice/General/Maxillofacial/Craniofacial Surgery: _____

Graduate Training, if any, in the basic sciences applicable to clinical maxillofacial surgery (anatomy, physiology, pathology, bacteriology, biochemistry, etc.): _____

MEDICAL/DENTAL SOCIETY MEMBERSHIPS

APPLICANT SIGNATURE

Signature: _____ Date: _____

Have you attended an ASMS Annual Meeting? YES NO **YEAR:** _____

❧ DOCUMENTATION CHECK LIST ❧

- Letter of Sponsorship from Active/Senior ASMS Member
- Letter of Endorsement from Active/Senior ASMS Member
- Copy of curriculum vitae
- Application fee (\$50 US Dollars)

RETURN TO:

American Society of Maxillofacial Surgeons
ASMS Membership Committee
444 East Algonquin Road
Arlington Heights, IL 60005
Phone: (800) 849-4682
Fax: (847) 709-7545
Email: asms@plasticsurgery.org
www.maxface.org