



## APPLICATION FOR MEMBERSHIP

### Virginia Society of Oral and Maxillofacial Surgeons

3460 Mayland Ct., Ste. 110  
Richmond, VA 23233

#### Contact Information

Full Name: \_\_\_\_\_ Degree(s) \_\_\_\_\_

Date and Place of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

#### Office Information

Primary Office Location: \_\_\_\_\_

Office Address: \_\_\_\_\_  
\_\_\_\_\_

Office Phone: \_\_\_\_\_

Office Fax: \_\_\_\_\_

Are you a member of a group practice?    Yes                      No

If yes, name or partners in office:  
\_\_\_\_\_

## EDUCATION

### College or University:

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Name

Dates Attended

### Dental/Medical Education:

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Name

Dates Attended

### Post Graduate Education: (Residency)

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Name

Dates Attended

### Military Experience:

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Hospital/ Unit Position

Dates

### Hospital Affiliations:

1. \_\_\_\_\_  
Hospital name Date of Appointment

2. \_\_\_\_\_  
Hospital name Date of Appointment

### Professional Memberships:

Local: \_\_\_\_\_

State: \_\_\_\_\_

National: \_\_\_\_\_

Board Certification Y \_\_\_\_\_ N \_\_\_\_\_

\_\_\_\_\_ Year Certified

\_\_\_\_\_ Year Re-certified

**Professional References**

Please supply two (2) letters of references

Practitioner's Name

Address

Phone Number

\_\_\_\_\_

\_\_\_\_\_

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