International Association of
Oral and Maxillofacial Surgeons

Trainee Verification Form for IAOMS Membership

Applicant Name: Date:

Address:

City: State/Province:

Country: Postal Code:

Email: Mobile Phone:

Trainee Verification To Be Completed By Program Director

This is to confirm that the above named candidate for IAOMS membership is enrolled in the oral and maxillofacial training program at our institute.

OMS Training Program:

Address:

City: State/Province:

Postal Code: Country:

Anticipated Completion Date:

Additional Comments:

Program Director Name:

Program Director Email: Date:

Program Director Signature:

Return This Form To:

Katie Cairns *(kcairns@iaoms.org)*

+1-773-647-1789 (fax)