



A NATIONAL SOCIETY OF ORAL & MAXILLOFACIAL ADMINISTRATORS  
JOINING ADMINISTRATORS WITH SUPPORT

# 2012 MEMBERSHIP APPLICATION

2012 MEMBERSHIP DUES ARE \$200. MAKE CHECKS PAYABLE TO: JAWS SOCIETY.

## MEMBER PROFILE

First & Last Name \_\_\_\_\_

Your Title \_\_\_\_\_

Professional Certifications (e.g. CPA, FACMPE, CMPE) \_\_\_\_\_

Name of Group/Practice (as it should appear in the directory) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

Office Email Address \_\_\_\_\_

Indicate the number of years of management in Oral and Maxillofacial Surgery: \_\_\_\_\_

Which of the following best describes your practice type?

- Private Practice
- Solo Practice
- Office with out-patient Surgery Center
- University Affiliated
- Hospital based/owned
- Multiple Offices (provide the number of offices) \_\_\_\_\_

Please provide the names of your Oral and Maxillofacial Surgeons:

Name \_\_\_\_\_ Name \_\_\_\_\_

Name \_\_\_\_\_ Name \_\_\_\_\_

Name \_\_\_\_\_ Name \_\_\_\_\_

What is the total number of FTEs (excluding physicians) on your staff? \_\_\_\_\_

*I agree to conform to the Association's rules and regulations. I certify that all the information submitted by me on this application is true and complete, and I understand that if any false information, omissions or misrepresentations are discovered, my application may be rejected and/or terminated at any time with/or without notice.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

**2012 membership dues are \$200. Make your check payable to JAWS Society.**

*Please mail the completed application with your payment to the JAWS Society; 1901 North Roselle Road, Suite 920, Schaumburg, IL 60195. Fax the completed form to 847.885.8393.*