The American Board of Oral & Maxillofacial Radiology, Inc.

APPLICATION FOR THE CERTIFICATION EXAM

TYPE OR PRINT ALL INFORMATION. The original copy of this application must be completed and returned to the Secretary-Treasurer via ***email***. If space limitations prevent complete listing of information, continue on supplementary pages. Identify such items by item number used on form.

1. Last Name _____ First Name _____ Middle Name _____

2. Date of Birth: _____

3. Mailing address:

Street Number and Address: _____ APT#: _____

City: _____ State: _____ Zip Code: _____

4. Contact information:

Phone number: _____ E-mail address: _____

5. PRE-PROFESSIONAL EDUCATION

College/University	Location	Dates (MM/YY TO MM/YY)	Degree Granted

6. DENTAL SCHOOL EDUCATION

College/University	Location	Dates (MM/YY TO MM/YY)	Degree Granted

7. GRADUATE/POST-GRADUATE EDUCATION (RESIDENCY, GRADUATE SCHOOL, ETC.)

College/University	Location	Dates (MM/YY TO MM/YY)	Degree Granted

8. CURRENT OR PAST TEACHING POSITIONS (CERTIFIED WITH ATTACHED LETTER/S FROM DEAN OR ADMINISTATOR)

Institution	Position Held/Rank	Dates (MM/YY TO MM/YY)

9. TOTAL NUMBER OF YEARS IN EXCLUSIVE CONTINUOUS PRACTICE OF ORAL & MAXILLOFACIAL RADIOLOGY INCLUDING TRAINING:_____Years_____Months.

10. MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS (INCLUDING POSITIONS HELD)

Organization	Position Held	Dates (MM/YY TO MM/YY)

11. NAME and E-MAIL OF ORAL & MAXILLOFACIAL RADIOLOGY PROGRAM DIRECTOR WHO WILL PROVIDE LETTER (see “Application Information” Brochure)

Name	E-Mail

12. OTHER BOARD CERTIFICATIONS

Board Name	Certification date

13. UPLOAD YOUR PHOTO ONLINE

14. This application is made by me to the American Board of Oral & Maxillofacial Radiology for examination by the said Board in accordance with its rules. I enclose the application fee which is not refundable. Furthermore, I understand that the examination fee is to be paid by me to the American Board of Oral & Maxillofacial Radiology when I am accepted for examination and that this amount is not refundable. In addition, I agree that:

A. The American Board of Oral & Maxillofacial Radiology may, at its discretion, investigate my standing and reputation as a radiologist, including my reputation for complying with the standard of ethics of the profession, and that this investigation may take place prior or subsequent to any examination given by the Board; and

B. The American Board of Oral & Maxillofacial Radiology may, at its discretion, refuse to examine me, or having examined me may refuse a certificate based upon its investigation, and I understand that said refusal shall be final; and

C. In the event the American Board of Oral & Maxillofacial Radiology refuses to grant a certificate on the basis set forth in subparagraph (b) above, I hereby and herewith waive any right I may have to question said refusal in any court of law or equity or other tribunal, and I also waive any right to claim which I may have in court of law or equity or other tribunal, in the event of such refusal to a return of my fees.

I also state that I am responsible for the information herein recorded and that all statements are true.

Candidate's Signature	Date

Notary Public: _____ Date:_____

Official Seal and Signature