CANADIAN ACADEMY OF ORAL AND MAXILLOFACIAL RADIOLOGY

ACADÉMIE CANADIENNE DE RADIOLOGIE BUCCALE ET MAXILLOFACIALE

MEMBERSHIP APPLICATION FORM

LAST NAME _____

GIVEN NAME(S) _____

BUSINESS ADDRESS _____

_____

CITY _____ **PROVINCE OR STATE** _____

COUNTRY _____ **POSTAL CODE OR ZIP CODE** _____

HOME OR MOBILE PHONE _____ **OFFICE PHONE** _____

E-MAIL _____

POST-SECONDARY EDUCATION

DEGREE/CERTIFICATE	AREA OF STUDY	INSTITUTION	DATES

SPECIALTY CERTIFICATIONS (e.g. Royal College of Dentists of Canada, or other radiology specialty certification)

CERTIFICATION	DATE OF CERTIFICATION

SUMMARY OF YOUR ACTIVITY IN ORAL AND MAXILLOFACIAL RADIOLOGY (you may include a copy of your curriculum vitae)

MEMBERSHIPS IN PROFESSIONAL DENTAL/MEDICAL ORGANIZATIONS (e.g. associations, study clubs, societies)

PROFESSIONAL ORGANIZATION	DATE OF MEMBERSHIP

QUALIFICATIONS FOR MEMBERSHIP CLASSIFICATIONS *(Note that these qualifications are subject to change in accordance with amendments to the Academy's Constitution and Bylaws.)*

Active Membership is open to:

1) A dentist who is a member in good standing with his or her provincial regulatory authority or another nationally recognized dental association, and one of the following:
   i) A certified oral radiologist or an oral radiologist who has earned recognition in oral and maxillofacial radiology by graduate or post-graduate training that satisfies the membership requirements of the Elective Officers, or
   ii) A dentist who is devoting at least 75% of his or her time to the practice or teaching of oral and maxillofacial radiology, and who satisfies the membership requirements of the Elective Officers; or

2) A professional whose major work and expertise is within the scope of oral and maxillofacial radiology and who satisfies the membership requirements of the Elective Officers.

Associate Membership is open to:

1) A dentist who is a member in good standing with his or her provincial regulatory authority or another nationally recognized dental association, and who is devoting part of his or her practice, teaching, and/or research program to oral and maxillofacial radiology, and who satisfies the membership requirements of the Elective Officers; or

2) An individual who is devoting less than 75% of his or her time working in the field of oral and maxillofacial radiology, and who has demonstrated interest in oral and maxillofacial radiology and satisfies the membership requirements of the Elective Officers.

Student Membership is open to:

1) A student in an accredited graduate or post-graduate program in oral and maxillofacial radiology with a supporting letter from the director of the graduate/post-graduate program and satisfaction of the membership requirements of the Elective Officers; or

2) A student in an accredited undergraduate dentistry program who has demonstrated appreciable interest in the field of oral and maxillofacial radiology, in conjunction with a supporting letter from an active CAOMR member and satisfaction of the membership requirements of the Elective Officers; or

3) A student in an accredited undergraduate or graduate program that is deemed by the Elective Officers to be within the scope of oral and maxillofacial radiology, in conjunction with a supporting letter from an active CAOMR member and satisfaction of the membership requirements of the Elective Officers.

CHECK CLASS OF MEMBERSHIP FOR WHICH YOU ARE APPLYING *(Please note that the CAOMR Executive reserves the right to determine the appropriate classification of membership for the applicant.)*

- ☐ Active
- ☐ Associate
- ☐ Student

For **ACTIVE MEMBERSHIP**, two letters of recommendation are required from either active members of CAOMR, or specialists in oral and maxillofacial radiology who are members in good standing in their national specialty organization, or in the International Association of Dento-Maxillo-Facial Radiology. Please indicate below the contact information of the individuals who will be submitting letters.

NAME OF REFEREE #1 _____

BUSINESS ADDRESS _____

CITY _____ **PROVINCE OR STATE** _____

COUNTRY _____ **POSTAL CODE OR ZIP CODE** _____

OFFICE PHONE _____ **E-MAIL** _____

NAME OF REFEREE #2 _____

BUSINESS ADDRESS _____

CITY _____ **PROVINCE OR STATE** _____

COUNTRY _____ **POSTAL CODE OR ZIP CODE** _____

OFFICE PHONE _____ **E-MAIL** _____

For **ASSOCIATE MEMBERSHIP**, one letter of recommendation is required from either an active member of CAOMR, or a specialist in oral and maxillofacial radiology who is a member in good standing in his national specialty organization, or in the International Association of Dento-Maxillo-Facial Radiology. Please indicate below the contact information of the individual who will be submitting a letter.

NAME OF REFEREE _____

BUSINESS ADDRESS _____

CITY _____ **PROVINCE OR STATE** _____

COUNTRY _____ **POSTAL CODE OR ZIP CODE** _____

OFFICE PHONE _____ **E-MAIL** _____

For **STUDENT MEMBERSHIP**, a letter from the director of the graduate/postgraduate program is required. The letter must give detailed information concerning the character and qualifications of the candidate. Please indicate below the contact information of the individual who will be submitting a letter.

NAME OF REFEREE _____

BUSINESS ADDRESS _____

CITY _____ **PROVINCE OR STATE** _____

COUNTRY _____ **POSTAL CODE OR ZIP CODE** _____

OFFICE PHONE _____ **E-MAIL** _____

Please ensure all reference letters are e-mailed to e@canaray.com

PLEDGE: I hereby apply for membership in the Canadian Academy of Oral and Maxillofacial Radiology and certify that I agree to uphold the provisions of the Academy's Constitution and Bylaws.

Signature of applicant _____ Date _____

Your payment in Canadian dollars for annual membership dues (<u>$150.00</u> for Active Members, <u>$50.00</u> for Associate Members) plus a <u>$10.00</u> application fee must accompany this application. Applicants for Student Membership are <u>not</u> required to send any payment. Existing Student Members applying for a transfer of status from Student to either Active or Associate Membership at the time of completion of their program are also <u>not</u> required to send payment, as membership fees are waived during the first year of Active or Associate Membership.

PAYMENT ENCLOSED:

- ☐ Active $150.00 + application fee $10.00
- ☐ Associate $50.00 + application fee $10.00

FEES MAY BE PAYABLE BY <u>INTERAC E-MAIL MONEY TRANSFER OR CHEQUE</u>

- ☐ E-mail e-transfer to the CAOMR Treasurer-Secretary (Trevor Thang at trevor.thang@utoronto.ca).
- ☐ Cheque made payable to Canadian Academy of Oral and Maxillofacial Radiology.