

FOR OFFICE USE ONLY

Application No.	Application Fee	Exam. Fee	Re-exam. Fee	Re-Exam. Fee	Dentistry Grad.	CV	Photo
Date Received	Date Received	Date Received	Date Received	Date Received	PD Letter		



# The American Board of Oral & Maxillofacial Radiology, Inc.

## APPLICATION FOR CERTIFICATION

TYPE OR PRINT ALL INFORMATION. "APPLICATION INFORMATION" brochure has additional information. The original and 5 copies of this application must be completed and returned to the Secretary-Treasurer. If space limitations prevent complete listing of information, continue under item 14 or on supplementary pages. Identify such items by item number used on form.

1. NAME (LAST, FIRST, MIDDLE)	2. DATE OF BIRTH    AGE    PLACE OF BIRTH    CITIZENSHIP (COUNTRY)
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3. OFFICE ADDRESS (INSTITUTION AND STREET ADDRESS)	4. RESIDENCE ADDRESS (NO. AND STREET)
CITY, STATE/PROVINCE, COUNTRY, ZIP/POSTAL CODE	CITY, STATE/PROVINCE, COUNTRY, ZIP/POSTAL CODE
OFFICE TELEPHONE (INCL. AREA CODE)	RESIDENCE TELEPHONE (INCL. AREA CODE)
OFFICE FAX (INCL. AREA CODE)	RESIDENCE FAX (INCL. AREA CODE)
OFFICE E-MAIL	RESIDENCE E-MAIL

### 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 ADMINISTRATOR)

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
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10. MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS (INCLUDING POSITIONS HELD)

Organization	Position Held	Organization	Position Held

11. NAME OF ORAL & MAXILLOFACIAL RADIOLOGY PROGRAM DIRECTOR WHO WILL PROVIDE LETTER (see "Application Information" Brochure)

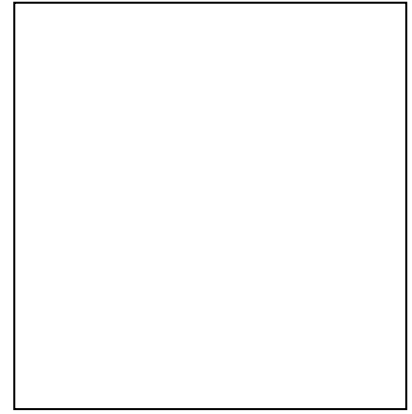
NAME
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12. OTHER BOARD CERTIFICATIONS

Board	Year	Board	Year

13. ADDITIONAL COMMENTS  
(OTHER EVIDENCE OF EXPERTISE, OR USE THIS AREA TO EXPAND ON PREVIOUS ITEMS)

14. ATTACH PHOTO HERE



15. 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.

APPLICANT'S SIGNATURE (IN PRESENCE OF NOTARY)	DATE	NOTARY SEAL
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EXAMINATION RESULTS

	PHYSICS & TECHNIQUES		BIOLOGY & PROTECTION		INTERPRETATION (WRITTEN/ORAL)		PRESIDENT
DATE	PASS	FAIL	PASS	FAIL	PASS	FAIL	
DATE	PASS	FAIL	PASS	FAIL	PASS	FAIL	
DATE	PASS	FAIL	PASS	FAIL	PASS	FAIL	

11/06