OACTS MEMBERSHIP APPLICATION

Please email completed application to info@oacts.ca OR
Mail to: OACTS 2075 Bayview Ave Suite M1-524, Toronto, Ontario M4N3M5

NAME

Last	First	Middle Initial
Date of Birth (mm/dd/yyyy)	Citizenship	

OFFICE ADDRESS (mailing address)

Street		Suite Number
City	Province	Postal Code
Telephone	Fax (to be used for Referrals)	Email

SPECIALTY (check appropriate box/es)

☐ OMFS ☐ PLS
☐ OTO-HNS ☐ OCULOPLASTICS

Other

DEGREES AND BOARD CERTIFICATION (check appropriate boxes)

☐ BSc ☐ MSc ☐ MA ☐ MBA ☐ MPH ☐ MD ☐ DDS ☐ DMD ☐ PhD ☐ FRCSC ☐ FRCS ☐ FACS

Other

YEAR BOARD CERTIFIED

YEARS IN PRACTICE

ACADEMIC APPOINTMENT(S)

Title 1	Title 2
Institution	Institution

HOSPITAL AFFILIATION(S)

EDUCATION INFORMATION

EDUCATION	INSTITUTION	DEGREE	DATE COMPLETED (mm/dd/yyyy)
Residency Training			
Medical School			
Graduate School			

CMF FELLOWSHIPS

FELLOWSHIP 1		FELLOWSHIP 2	
Fellowship Director:		Fellowship Director:	
Fellowship Start/Finish Dates:		Fellowship Start/Finish Dates:	
Institute:		Institute:	

PRACTICE PROFILE *(Please indicate percentage; total should equal 100%)*

CMF Trauma/Fractures	
CMF Adult Reconstruction/Tumour	
Orthognathic	
CMF Pediatric Reconstruction	
Other (Describe):	
	100%

☐ **I agree/☐ do not agree to have my Referral information Form displayed on the OACTS website**

☐ **I agree/ ☐ do not agree to have my photo headshot displayed on the OACTS website**

Signature: ______________________________________

Date: ___________________________
(mm/dd/yyyy)

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