EUROPEAN ASSOCIATION OF ORAL MEDICINE

Diploma in Oral Medicine

Application Form

(please send four copies to the Secretary-General of the EAOM)

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ID PHOTO

LAST NAME: _____

FIRST NAME: _____

DATE OF BIRTH (day/month/year): _____

MALE: ( ); FEMALE: ( )

HOME ADDRESS: _____

_____

WORK ADDRESS: _____

_____

PHONE: _____
FAX: _____
E-MAIL: _____
NATIONALITY: _____

UNDERGRADUATE QUALIFICATIONS

(DENTAL, DATE RECEIVED): _____ UNIVERSITY: _____

(MEDICAL, DATE RECEIVED): _____ UNIVERSITY: _____

RECOGNITION AS SPECIALIST IN ORAL MEDICINE (if applicable)

DATE: _____ PLACE: _____

HIGHER (2ND) UNIVERSITY QUALIFICATIONS (DOCTORATE):

(DATE RECEIVED): _____ UNIVERSITY: _____

RESEARCH PROJECTS, PUBLICATIONS AND PRESENTATIONS AT NATIONAL OR INTERNATIONAL MEETINGS (please use a separate sheet):

Publications (incl. chapters or text books): please use a separate sheet
Presentation (national or international meetings only): please use a separate sheet

ORAL MEDICINE TRAINING: INSTITUTIONS WHERE TRAINING WAS UNDERTAKEN WITH DATES):

INSTITUTION: _____ DATE: _____

INSTITUTION: _____ DATE: _____

(CANDIDATES HAVE TO SUBMIT COPIES OF ALL DOCUMENTS CONCERNED)

_____

SIGNATURE