



APPLICATION FOR MEMBERSHIP

Date: _____

How did you hear of the IAOM? _____

1. Name: _____
Last First Middle Initial Title

Date of birth: _____

2. Home address & zip: _____
 prefer for mailing _____

3. Office address & zip: _____
 prefer for mailing _____

4. Home telephone: _____ Business telephone: _____

5. Email Address: _____ Fax: _____

6. Website Directory: The IAOM Website Directory is open to the public and anyone can access this information. By circling and listing information under #6, I give permission to the IAOM to post my name as well as the following information that I specify on the IAOM website directory (please circle) email address work phone

Which city(ies) or metropolitan area would you like listed on the website? _____

7. Education: Name of institution(s), degree, major and year of graduation:
1. _____
2. _____
3. _____
4. _____

8. Professional references: Give three with complete addresses and phone numbers.
1. _____
2. _____
3. _____

9. List prior training in orofacial myofunctional disorders

	Location	Instructor	Amount of Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

10. Please list other professional organizations to which you presently belong:

	State	National
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

11. Please list below your professional experience(s):

12. Type of Membership for which you are applying – Check one

- ACTIVE** (Please enclose \$150 for annual dues.) Please send **copy of official transcript of highest degree or copy of professional license** with dues check. **Must accompany application.**
- ASSOCIATE** (Please enclose \$140 for annual dues.) An associate member does not practice Orofacial Myology.

PLEASE SEND A CHECK OR MONEY ORDER ALONG WITH THIS APPLIATION TO:

INTERNATIONAL ASSOCIATION OF OROFACIAL MYOLOGY
 ATTN: JENNIFER ASHER, ADMINISTRATIVE COORDINATOR
 P.O. Box 278
 Georgetown, KY 40324

For future information, please contact the IAOM office at:
 Phone: (502) 370-4071
 Fax: (503) 345-6858
 Email: iaomec@msn.com
 Website: www.iaom.com

“MY SIGNATURE BELOW SIGNIFIES THAT ALL OF THE INFORMATION HEREIN GIVEN IS CORRECT AND THAT I HAVE READ AND ACCEPT THE CODE OF ETHICS OF THE IAOM” (see www.iaom.com/iaom_membership.html).

Applicant’s signature

Date

NOTE: In order to maintain the highest professional standard in the treatment of orofacial myofunctional disorders, the IAOM has a certification process. Active members are strongly encouraged to attain CERTIFIED status. For further information regarding this process, please contact the Executive Coordinator.