



**EVALUATION FORM OF CANDIDATE FOR MEMBERSHIP
(PLEASE PRINT OR TYPE)**

Dr. _____ is listed as a candidate for membership in the California Association of Oral and Maxillofacial Surgeons. I wish to offer the following appraisal of his/her qualifications. I have known the applicant for _____ years.

Please comment directly on each of the items below:

CHARACTER: Morals, trustworthiness, ideals

COMPETENCE: Professional capacity, education, fitness

ETHICS: Relations with medical-dental colleagues, public

JUDGEMENT: Tact, diplomacy, decisiveness

STABILITY: Self-control, tolerance, social aptitude

ADDITIONAL COMMENTS:

NOTE: Evaluator completing form must be a current AAOMS Fellow/Member

Return completed form via Email:
pam@calaoms.org **Fax:**
(916) 772-9220

Mail: CALAOMS
950 RESERVE DR STE 120
ROSEVILLE CA 95678-1351

Name (Please Print)

Signature Date

Address

City State Zip Code