



Taiwan Academy of Oral & Maxillo-Facial Radiology

Membership Application Form

Name				Hat off Photo (2 inches, free attached)	
Birthday	Yr	Mon	Day		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Passport No.			Certificate No.		Dentist, No. _____
					Radiologist, No. _____
Tel.			Fax		
Cell Phone			Email		
Contact Address					
Education	1. _____				
	2. _____				
Experience	1. _____				
	2. _____				
	3. _____				
Academic Expertise	1. _____		2. _____		
			3. _____		
Kind of Membership	<input type="checkbox"/> General <input type="checkbox"/> Permanent <input type="checkbox"/> Student				
Application Date	Yr	Mon	Day	Applicant Signature	
Review Comment	<input type="checkbox"/> Qualify for _____ membership <input type="checkbox"/> Non-qualify, Further documents required : _____ Chairman : _____ President : _____				
Addendum	Addendum : Please use registered mail sending the copies of education & experience documents as well as the application form to: No.100, Tzyou 1st Road, Kaohsiung 807, Taiwan <u>Taiwan Academy of Oral & Maxillo-Facial Radiology</u> Tel : 886-7-3121101~7125				