Royal Australasian College of Dental Surgeons
Let knowledge conquer disease

FOMS04 – OMS Trainee occupying an Accredited Post

Please type or print in BLOCK letters your responses in this form
Completed forms should be submitted via email to oms@racds.org

Personal Details

First Name		RACDS ID *(if known)*	
Last Name			
Other Names		Date of Birth *(dd/mm/yy)*	
Email			
Phone	M	H	W
Mailing Address			

Are you of Aboriginal, Torres Strait Islander or Māori heritage?

- ☐ No
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Māori

Training

Year commence OMS Training Program (BST(OMS) or OMS 1)	◯ Pre-2004	◯ 2004 - 2009	◯ 2010 and beyond

☐ **OMS 1**	**State Date:**		**Expected End Date:**	
	1st or only Position Occupied			
	2nd Position Occupied *(if applicable)*			
☐ **OMS 2**	**State Date:**		**Expected End Date:**	
	1st or only Position Occupied			
	2nd Position Occupied *(if applicable)*			
☐ **OMS 3**	**State Date:**		**Expected End Date:**	
	1st or only Position Occupied			
	2nd Position Occupied *(if applicable)*			
☐ **OMS 4**	**State Date:**		**Expected End Date:**	
	1st or only Position Occupied			
	2nd Position Occupied *(if applicable)*			

RACS courses (to be completed before OMS 3)	☐ ASSETT	☐ EMST	☐ CCrISP

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Training Institution this training year	
Hospital Name	
Address	
Start Date	

Supervision for this training year						
Supervisor's Name						
Phone	M		H		W	
Email						
Address						

Supervisor Signature _____ **Date** _____
(Unsigned applications will not be processed)

Director of Training Declaration

I confirm that the above person is currently a trainee in Oral and Maxillofacial Surgery at the Royal Australasian College of Dental Surgeons and that the above post details (if applicable) are correct.

DoT Signature _____ **Date** _____
(Unsigned applications will not be processed)

Please Print Name:	
Trainee Commencement Date:	

Submission Checklist

- ☐ The payment for the trainee registration fee is enclosed
- ☐ I have signed the form
- ☐ The form has been signed by my Director of Training
- ☐ All required sections are filled out, including section 2

Please Note: *The College also must receive the following documents (if not already submitted)*

- ☐ Six Monthly Assessment Feb – July or Aug-Jan for the previous year (signed by Supervisor of Training and Director of Training)
- ☐ Annual Logbook Summary (signed by Director of Training)

Trainee Declaration

As a registered trainee with the Oral and Maxillofacial Surgery (OMS) training program of the Royal Australasian College of Dental Surgeons Incorporated (RACDS), I agree to abide by the terms and conditions of the training program as stated in the Handbook.
I understand that financial membership of the RACDS must be maintained for the duration of training.
I acknowledge that my information will be handled in accordance with the RACDS Privacy Policy and I agree that program information may be used for the purposes of evaluation and research.

Trainee Signature _____ **Date** _____
(Unsigned applications will not be processed)

Payment Options		
Payment Amount	OMS Trainee occupying and Accredited Post $AU_____ *(Please refer to the Fee Schedule on the College website for the applicable fee amount)*	
☐ Credit Card	Card Type	◯ **MasterCard** ◯ **Visa**
	Card Holder Name	
	Card Number	
	Expiry Date	
	CCV	
	Card Holder Signature	
☐ Cheque	1. Made payable to "Royal Australasian College of Dental Surgeons" 2. In Australian dollars and drawn on an Australian bank (bank fees may apply otherwise)	