Royal Australasian College of Dental Surgeons
Let knowledge conquer disease

FOMS11 – Completion of Oral and Maxillofacial Surgery Training Program

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)*	
Training Centre			
Current Hospital			

Rotation Details *(Education Officer – OMS to complete)*

	Start Date	End Date	Location
BST (OMS) or OMS 1 Year			
OMS 2 Year			
OMS 3 Year			
OMS 4 Year			
Has a total of 4 years of training been completed?	☐ Yes	Signature _____	

Director of Training to complete

Completion of Training (final day of training)	Date: *(Date MUST be entered in order for FOMS11 to be processed)*
Final Logbook Summary – Conclusion of Training	Date:
Procedures noted in Final Exam Eligibility Assessment addressed	☐ Satisfactory
	☐ Unsatisfactory
Satisfactory Six Month Formative Assessment for Final Term	☐ Satisfactory
	☐ Unsatisfactory – if unsatisfactory, please email oms@racds.org for further advice.
Training Portfolio Reviewed and Complete	Date:
Mandatory Research Requirements	☐ Not required
	☐ Required and Complete
	☐ Required, Not Complete

Sign off

I, *(type or print DoT name)* _____, Director of Training of *(insert training centre)* _____ Certify that *(insert trainee name)* _____ has completed the training requirements for the training patheway for the RACDS for Fellowship in Oral & Maxillofacial Surgery FRACDS(OMS).

Date: _____

Signature: _____