



<h2 style="margin: 0;">Annual Registration for OMS Trainee Occupying an Accredited Post</h2>	FOMS 02
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**Instructions**

- This form is for Oral and Maxillofacial Surgery (OMS) Trainees occupying an accredited post in Australia or New Zealand and are registering at the beginning of each training year in accordance with the [Accredited Training in OMS Handbook](#).
- Please complete this form and payment then request your Director of Training to sign before emailing to [omstraineer@racds.org](mailto:omstraineer@racds.org) by 15 February 2024. Late and incomplete registrations will not be accepted.

<b>Applicant Details</b>
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First name					RACDS ID <i>(if known)</i>		
Last name							
Other names					Date of birth <i>(dd/mm/yy)</i>		
Email address							
Phone	M		H		W		
Mailing address							

<b>Training</b>
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Year commenced in OMS Training Program			
Previous period of interrupted training	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Year(s): <span style="border-bottom: 1px solid black; display: inline-block; width: 50px;"></span>
RACS courses completed before OMS 3 training <i>(Please attach evidence of completion)</i>	<input type="checkbox"/> ASSETT	<input type="checkbox"/> EMST	<input type="checkbox"/> CCriSP
Current training year	Start date:	Expected end date:	
<input type="checkbox"/> OMS 1	First or only training post <span style="border-bottom: 1px solid black; display: inline-block; width: 400px;"></span>		
<input type="checkbox"/> OMS 2	Supervisor of Training <span style="border-bottom: 1px solid black; display: inline-block; width: 400px;"></span>		
<input type="checkbox"/> OMS 3	Second training post <span style="border-bottom: 1px solid black; display: inline-block; width: 400px;"></span>		
<input type="checkbox"/> OMS 4	Supervisor of Training <span style="border-bottom: 1px solid black; display: inline-block; width: 400px;"></span>		



### Director of Training Declaration

I hereby declare that Dr \_\_\_\_\_ is currently an OMS trainee in our training centre.  
The above training post and supervisor details are correct.

Director of Training

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Trainee Declaration

I hereby declare to abide by the terms and conditions of the OMS Training Program as stated in the OMS Handbook and Royal Australasian College Dental Surgeons (RACDS) policies. I acknowledge that my information will be handled in accordance with the RACDS [Privacy Policy](#) and may be used for the purposes of evaluation and research.  
I confirm that I will pay the full annual fee or installments to the College as per the selected payment schedule.

Trainee signature \_\_\_\_\_

Date \_\_\_\_\_

### Payment

Please select your preferred payment schedule (i.e., annual, biannual or quarterly) and click on the relevant hyperlink below to pay the [registration fee](#) online via the RACDS website. Subsequent biannual and quarterly payments are processed by the due dates. Refer to the RACDS [Refund Policy](#) for information on refunds.

Date of payment

Payment schedule

[Annual](#)

[Biannual](#)

[Quarterly](#)

Amount paid

AUD

Invoice/ receipt  
number