Form revised 8/13

THE AMERICAN BOARD OF ORAL & MAXILLOFACIAL PATHOLOGY
EXAMINATION REGISTRATION FORM

FIRST TIME APPLICANTS:

THIS FORM MUST BE RECEIVED WITHIN 30 DAYS AFTER NOTIFICATION OF APPROVAL.

☐ I wish to take this year's examination.

☐ I will not be taking this year's examination.

ALL OTHER CANDIDATES:

THE FINAL FILING DATE FOR THIS FORM IS MAY 15.

I wish to register for the ABOMP certifying examination for _______.
(Year)

☐ I have a current application on file and have never sat for the examination.

☐ I have a current application on file and wish to retake the examination.
The re-examination fee of $1000 is enclosed.

Mailing address: (If to a hospital or medical center, include name of institution.)

____
Institution

____
Street and number

____
City State Zip Code

☐ This is a new address.

Telephone where I may be reached (daytime):

____
Area Code Number

____
Name (please type or print)

Your signature indicates receipt and agreement with the behavioral guidelines.

____
Signature

RETURN THIS FORM TO:

The American Board of Oral & Maxillofacial Pathology
One Urban Centre, Suite 690
4830 W. Kennedy Boulevard
Tampa, Florida 33609