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 1 JUNE.

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