Southwest Society of Oral & Maxillofacial Surgeons

est . October 24, 1929

We are pleased that you have chosen to join the Southwest Society of Oral & Maxillofacial Surgeons!

Attached please find an application for membership in the Southwest Society of Oral and Maxillofacial Surgeons. Once complete, please return it to our office along with the $35.00 application fee to the following address or email:

Southwest Society of Oral & Maxillofacial Surgeons
Attn: Kelly Ann Shy, MHSM, Executive Director
4499 Medical Drive, Suite #190
San Antonio, Texas 78229

Upon receipt of the application, this information will be forwarded to our Membership Committee for verification of credentials. Following such, your application for membership will be presented to the general membership for vote at the next membership meeting.

The Southwest Society hosts a formal meeting one a year during the Southwest Society of Oral & Maxillofacial Surgeons Annual Meeting held in the Spring of each year. The deadline for applications is March 1st.

Should you have any questions regarding the application process, please contact our office via telephone: 210-614-3915 or via email: kellyannshy@alamoOMS.com.

Southwest Society of Oral and Maxillofacial Surgeons

Est. October 24, 1929

CREDIT CARD PAYMENT AUTHORIZATION FORM

Member Name: _____

Address _____

_____

Phone Number _____

Payment = $_____ To: SWSOMS

MasterCard/Visa/Discover/American Express

Card #_____ Expiration Date:_____/_____

CVV Code:_____ Billing Zip Code: _____

Cardholder Name: _____

Signature:_____Date:_____

PLEASE FAX YOUR COMPLETED CREDIT CARD AUTHORIZATION TO:

210-614-5234

-OR- EMAIL YOUR COMPLETED CREDIT CARD AUTHORIZATION TO:

kellyannshy@alamoOMS.com or laguilar@alamoOMS.com

please note that your email transmission, unless encrypted, is not secure. Should you wish to scan and password protect this information if encryption is not available, please use SWSOMS12 as the password for this document and our office will be able to open and retrieve this information.

Southwest Society of Oral

& Maxillofacial Surgeons

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Application for Membership

Applicant: _____ US Citizen Yes ☐ No ☐

Last ***First*** ***Middle*** ***Suffix***

Office Address: _____

Street ***Suite #***

_____

City ***State*** ***Zip***

_____

Office Phone ***Facsimile***

_____

Email ***Website***

Preferred Method of Contact: (Please Circle) **Office Address / Mailing Address / Email**

Mailing Address if Different From Office Address:

_____

_____

Date of Birth: _____/_____/_____ Spouse Name: _____

Month *Date* *Year*

Undergraduate: _____

College/University ***Date of Graduation*** ***Degree***

Dental: _____

Name of School ***Date of Graduation*** ***Degree***

Medical: _____

Name of School ***Date of Graduation*** ***Degree***

Residency Program:

_____

Dates of Entry ***Completion*** ***Name of School*** ***City*** ***State***

_____

Director / Contact ***Phone Number***

Additional Education: _____

Military Experience (Highest Rank held, professional experience and inclusive dates): _____

Applicant: _____
Last *First* *Middle*

Practice limited exclusively to Oral and Maxillofacial Surgery? Yes ___ No ____ Years in Practice: _____

State of Dental Licensure	*Date*	*State of Medical Licensure*	*Date*
Additional Licensure & State	*Date*	*Additional Licensure & State*	*Date*

Are you a member of the American Association of Oral and Maxillofacial Surgeons? Yes ☐ No ☐ _____ *Date*

Are you a diplomate of the American Board of Oral and Maxillofacial Surgey? Yes ☐ No ☐ _____ *Date*

If "No" to question 10, are you presently Board eligible? Yes ☐ No ☐ _____ *Date*

If "No" to questions 10 and 11, have you ever been Board eligible? Yes ☐ No ☐ _____ *Date*

Are you engaged in research or teaching of Oral and Maxillofacial Surgery in a dental or medical institution? Yes ☐ No ☐

List of Dental/Medical Societies to which you belong:

_____

_____

_____

Present Hospital Affiliations:

Hospital	*City*	*State*	*Staff Category*
Hospital	*City*	*State*	*Staff Category*
Hospital	*City*	*State*	*Staff Category*
Hospital	*City*	*State*	*Staff Category*

Endorsement from Active or Life members of Southwest Society of Oral and Maxillofacial Surgeons:

Name	*Name*
Address	*Address*
City, State and Zip Code	*City, State and Zip Code*
Signature of Sponsor	*Signature of Sponsor*

* Please list on a separate sheet any contributions to dental/medical literature, essays presented and research activities
* Please attach letter of successful completion of formal trainin gfrom the program director (required).
* Please include payment of $35.00 of the membership application fee made payable to: SWSOMS

Applicant Signature: _____ ***Date:*** _____

Applicant:_____

Last ***First*** ***Middle***

For Membership Committee Action

Application Received:

Letter verifying successful completion of formal training from the program director received

Action by Committee:

_____ _____

Accepted ***Rejected*** ***Deferrered*** ***Committee Chair Signature*** *Date*

Action by Society:

_____ _____

Accepted ***Rejected*** ***Deferrered*** ***Executive Director Signature*** *Date*