



## ***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  
12050 Vance Jackson Road #102  
San Antonio, Texas 78230

Fax Number 210-888-1363

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 1<sup>st</sup>.

Should you have any questions regarding the application process, please contact our office via telephone: 210-988-0960 or via email: [kshy@tx-oms.org](mailto:kshy@tx-oms.org).



# *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: \_\_\_\_\_

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**PLEASE SCAN AND EMAIL YOUR COMPLETED CREDIT CARD  
AUTHORIZATION TO:**

**[kshy@tx-oms.org](mailto:kshy@tx-oms.org)**

*\*\*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 SWSOMS20 as the password for this document and our office will be able to open and retrieve this information.\*\**



# Southwest Society of Oral & Maxillofacial Surgeons

est. October 24, 1929

## 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 Surgery? 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:

<i>Hospital</i>	<i>City</i>	<i>State</i>	<i>Staff Category</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

_____ <i>Name</i>	_____ <i>Name</i>
_____ <i>Address</i>	_____ <i>Address</i>
_____ <i>City, State and Zip Code</i>	_____ <i>City, State and Zip Code</i>
_____ <i>Signature of Sponsor</i>	_____ <i>Signature of Sponsor</i>

\* 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*

*Deferred*

\_\_\_\_\_  
*Committee Chair Signature*

\_\_\_\_\_  
*Date*

Action by Society:

*Accepted*

*Rejected*

*Deferred*

\_\_\_\_\_  
*Executive Director Signature*

\_\_\_\_\_  
*Date*