Southwest Society of Oral and Maxillofacial Surgeons

Est. October 24, 1929

Tradition *Camaraderie* *Legacy*

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: lisa@jdsmenterprises.com

Southwest Society of Oral & Maxillofacial Surgeons
Attn: Lisa Aguilar, Associate Executive Director
12050 Vance Jackson Road, Suite #102
San Antono, Texas 78230
Fax: 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 membershipmeeting.

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: 210-988-0960 via email: Lisa@jdsmenterprises.com

We look forward to your active participation in the Southwest Texas Society of Oral & Maxillofacial Surgeons.

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Application for Membership

Applicant: ____ US Citizen: Yes____ No____
Last First Middle Suffix

Office Address: ____
Street Address Suite #

____
City State Zip Code

____
Office Phone Facsimile

____
Email

Preferred Method of Contact (please circle**):** Office Address / Mailing Address / Email (if different from above):

Mailing Address if Different from Above: ________________________

____
Street Address Suite #

____
City State Zip Code

Date of Birth: ______ / ______ / ______
Month Date Year

AAOMS Member: Yes ______ No _____ ABOMS Certified: Yes _____ No _____ Initial Certification Year: __________

Practice Limited to Oral and Maxillofacial Surgery? Yes: ______ No ______ Year in Practice: _________

Undergraduate: ____
College / University Date of Graduation Degree

Dental School: ____
Name of School State of Dental Licensure Degree

Medical School: ____
Name of School State of Medical Licensure Degree

Residency Program: ____
Name of School Date of Entry Completion Date

Applicant Signature: ___________________________________ Date: _______________

Please fax application to: 210-888-1363 or email: lisa@jdsmenterprises.com

Southwest Society of Oral and Maxillofacial Surgeons Credit Card Payment Form

Name: __________________________

CREDIT CARD PAYMENT: Amount: $_______________

Card #_____________-_____________-________________-________________

Expiration Date: _______ /_______ CVV Code: __________ Billing Zip Code: _____________

Cardholder Name: ____

Signature: ____

Please email receipt to: ____

Credit Card Payments can be faxed to our private facsimile number 210-888-1363 or sent via email as an encrypted PDF (Code: SWSOMS2024) to lisa@jdsmenterprises.com

12050 Vance Jackson Road Suite #102 San Antonio, Texas 78230 210-988-0960