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 via address, fax number or email below. following address or

Southwest Society of Oral & Maxillofacial Surgeons
Attn: Lisa Aguilar, Associate Executive Director
12050 Vance Jackson Road, Suite #102
San Antono, Texas 78230
Phone: 210-988-0960
Fax: 210-888-1363
email: lisa@jdsmenterprises.com

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 25th.

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

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