Texas Society of Oral and Maxillofacial Surgeons

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

Attached please find an application for membership in the Texas Society of Oral and Maxillofacial Surgeons. Once complete, please return it to our office via email: lisa@jdsmenterprises.com, Fax: 210-888-1363 or mail to the following address:

Texas Society of Oral & Maxillofacial Surgeons
12050 Vance Jackson Road
Suite #102
San Antonio, Texas 78230

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 Texas Society hosts formal meetings twice each year during the Southwest Society of Oral & Maxillofacial Surgeons Annual Meeting held in the Spring of each year and during the American Association of Oral & Maxillofacial Surgeons Annual Meeting in the Fall of each year. The deadline for applications is March 1st (for consideration at the Spring meeting)and August 1st (for consideration at the Fall meeting).

Following entry into the Texas Society as a Provisional Member, you will have two years within which to complete the Office Anesthesia Evaluation process. Once this is complete, your membership in the Society changes to Active Member effective the date of your successful completion of the Office Anesthesia Evaluation.

Should you have any questions regarding the application process, please contact our office via telephone: **210-988-0960** or via email: lisa@tractiontohealthy.com**.**

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

Application for Membership

Texas Society of Oral & Maxillofacial Surgeons

Applicant: _____
Last *First* *Middle* *Suffix*

Office Address: _____
Street *Suite #*

_____
City *State* *Zip*

_____
Office Phone *Facsimile*

_____
Email *Website*

Mailing Address:
(if different from above)

_____
Street *Suite #*

_____
City *State* *Zip*

_____
Phone *Facsimile*

Preferred Method of Contact: Office Address / Mailing Address / Email _____
Please Circle *If diferrent from above*

Date of Birth: _____ **Spouse Name:** _____
Month *Date* *Year*

Undergraduate:

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

Dental: _____
Name of School *Date of Graduation* *Degree*

_____
License # *Issuing State*

Medical: _____
Name of School *Date of Graduation* *Degree*

_____
License # *Issuing State*

Applicant: _____

Residency Program:

Date of Entry	*Date Complete*	*Name of School/Program*	*City*	*State*

Director / Contact *Phone Number*

Fellowship:

Date of Entry	*Date Complete*	*Name of School/Program*	*City*	*State*

Director / Contact *Phone Number*

Government Service:

Date of Entry *Date Complete* *Official Title/Rank*

Practice limited exclusively to Oral and Maxillofacial Surgery? Yes / No **Years in Practice:** _____
(excluding residency)

Professional Associations:

Publications/Papers:

Research:

Applicant: _____

Additional Contributions to the Specialty (i.e. teaching, lecturing, community service):

_____

_____

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

I agree by my signature to participate in the Office Anesthesia emergency evaluation program and/or such other evaluations as may be determined by the Board of Directors and approved by the membership unless I am exempt from participation under provisions of the American Association of Oral & Maxillofacial Surgeons.

_____
Signature/Date

By my signature below, I authorize the release of otherwise confidential information to the Association and its authorized representatives by sources such as official licensing or regulatory agencies, professional associations, hospital or other health care organizations, educational institutions, or other relevant sources.

_____
Signature/Date

For Membership Committee Action
Application Received:

Licensure in State of Texas Verified:
Date

OMS Residency Training Verified:
Date

Recommendation of Committee:

_____ _____ _____ _____ _____
Accept ***Reject*** ***Defer*** ***Committee Chair Signature*** *Date*

Action by Society:

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