



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 along with the \$40.00 application fee at the following address:

Texas 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 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 that of Active Member effective the date of the successful completion of the Office Anesthesia Evaluation.

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

Home Address: _____
Street Apartment #

_____ *City State Zip*

_____ *Phone Facsimile*

Spouse: _____ Preferred Method of Contact: Office Address / Email / Home Address
Please Circle

Date/Place of Birth: _____
Month Date Year City State

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*

