Delaware Valley Society of Oral & Maxillofacial Surgeons

DVSOMS

Membership Application

Name:_____ Date:_____
Last First MI Degree

Office Address:_____ Office Phone:_____
_____ Fax :_____
_____ E-Mail:_____

Home Address:_____ Home Phone:_____
_____
_____

Date of Birth:_____ Place of Birth:_____

Dental School:_____ Year of Graduation:_____

Oral & Maxillofacial Surgery Residency: (List institutions and dates)
_____
_____
_____

Years in Practice:_____ Board Certification: Y N Candidate (please circle)

Hospital Staff Appointments:
1. _____
2. _____
3. _____

AAOMS Registration Number:_____ Status: Active Life Retired Associate (please circle)

PSOMS Member: Y or N if No, list State Society:_____

Other Professional Society Memberships:
1. _____
2. _____
3. _____

Sponsors (obtain two signatures of endorsement from current member of DVSOMS)
1. _____ (signature) _____
2. _____ (signature) _____

Membership Application Fee and Current Year Dues:

Delaware Valley Society of Oral & Maxillofacial Surgeons Yearly Dues	$250.00
Application Fee	$ 25.00
Total Due: Payable to DVSOMS	$275.00

Mail to:
John Lignelli DMD
500 Heritage Drive
Pottstown, PA 19464

Signature:_____