



# MIRA

## MINIMALLY INVASIVE ROBOTIC ASSOCIATION

MIRA Membership Services  
 11300 W Olympic Blvd #600  
 Los Angeles CA 90064  
 Phone: 310-424-3353 ext. 134  
 Fax: 310-437-0585  
 Email : membership@mirasurgery.org  
 Web Site: www.mirasurgery.org

Application Date: \_\_\_\_\_

PLEASE TYPE OR PRINT CLEARLY

**PLEASE ACCEPT MY APPLICATION FOR THE FOLLOWING MEMBERSHIP CATEGORY (CHECK ONE):**

- ACTIVE MEMBER** – an active surgeon in General Surgery, Colon & Rectal Surgery, Urology, Gynecology, Thoracic Surgery, Head & Neck or Podiatric, and other surgical specialties who performs robotic interventions or actively involved in research or development. (Membership Dues: \$150 USD annually).
- CANDIDATE MEMBER** - a resident/fellow or graduate surgeon actively enrolled in a dedicated training program in which robotic interventions form a part of the core curriculum. (No dues during residency/fellowship). Candidate status is maintained for up to three (3) years to allow for these members to become integrated in minimally invasive robotic intervention.  
 Year Residency Completed: \_\_\_\_\_ Year Fellowship Completed: \_\_\_\_\_  
 Upon completion of residency/fellowship or when board certified, annual dues of \$150 USD will be paid for three (3) years following residency/fellowship. At the end of 3 years, member will be upgraded to Active Member status.
- ASSOCIATE MEMBER** – a physician, nurse, engineer and other healthcare professional actively involved in robotic surgery. (Membership Dues: \$100 USD annually)

**APPLICANT'S FULL NAME:**

\_\_\_\_\_  
 (LAST/FAMILY NAME) (FIRST/GIVEN NAME) (MIDDLE NAME OR INITIAL)

MD  DO  PhD  RN  LPN  PA  Other Degrees: \_\_\_\_\_

Date of Birth (month/day/year): \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**PROFESSIONAL ADDRESS:**

\_\_\_\_\_  
 (Association or Institution)

\_\_\_\_\_  
 (Department)

\_\_\_\_\_  
 (Street Address)

\_\_\_\_\_  
 (City) (State/Province) (Zip/Postal Code)

\_\_\_\_\_  
 (Telephone Number) (Fax Number) (E-Mail Address)

**MEDICAL EDUCATION:**

Medical School Institution	Dates Attended	Degree/Date
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Residency Institution	Dates Attended	Degree/Date
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Fellowship Institution	Dates Attended	Title/Department
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HOSPITAL APPOINTMENTS (List up to 3 most recent principle appointments only):

Name/Department/Location	Yr of Appt	Staff position/title

ACADEMIC APPOINTMENTS (Past and current):

University	Dates	Title

LICENSURE/SPECIALTY:

License State/Province/Country	Date Issued	License Number

Board Name/Specialty	Date of Certification

SURGICAL SOCIETY MEMBERSHIPS:

Name	Date of Membership	Office or position held

For the following three categories, list only information related to robotics:

RESEARCH

PRESENTATIONS

PUBLICATIONS

REFERENCE: The reference should always be a MIRA member. If you do not know a member please contact a board member of your specialty or a member of the membership committee.

Name (Please print clearly)	City/State	Phone or E-mail address
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Please email a copy of your CV to [membership@mirasurgery.org](mailto:membership@mirasurgery.org) or mail to administrative office.  
PLEASE ENCLOSE \$100 USD APPLICATION FEE:  
 A check (USD only) is enclosed with this application. Please make checks payable to MIRA.  
 I authorize you to charge my:  VISA  MasterCard  American Express

CC Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Amount: \_\_\_\_\_  
Cardholder Name: \_\_\_\_\_ Signature: \_\_\_\_\_