



Research Award Application

1. APPLICATION TYPE		<input type="checkbox"/> Dermatopathology	<input type="checkbox"/> Medical Dermatology	<i>Fellowship</i>	<i>Grant</i>	<input type="checkbox"/> Research Grant
<i>Career Development Award</i>		<input type="checkbox"/> Physician Scientist	<input type="checkbox"/> Sci. Human Appearance	<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Patient Directed Investigation	<input type="checkbox"/> Program Development
		<input type="checkbox"/> Dermatologic Surgery	<input type="checkbox"/> Women's Health	<input type="checkbox"/> Investigator Research	<input type="checkbox"/> Dermopath Grant	
		<input type="checkbox"/> Health Care Policy	<input type="checkbox"/> Research CDA	<input type="checkbox"/> Pediatric Dermatology		
2. TITLE OF PROJECT (Do not exceed 100 characters)						
3a. NAME (Last, First, Middle Initial)			3b. DEGREE (S)		3c. DATE OF BIRTH	
3d. CURRENT POSITION TITLE			3e. CURRENT MAILING ADDRESS			
3f. POSITION DURING YEAR OF PROPOSED SUPPORT						
3g. TELEPHONE AND FAX (Area Code, Number and Extension)			3h. E-MAIL ADDRESS			
Tel _____ Fax _____						
3i. U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO If no, visa status				3j. DERMATOLOGY FOUNDATION MEMBER <input type="checkbox"/> YES <input type="checkbox"/> NO		
3k. AMOUNT REQUESTED \$ _____ for period beginning _____ ending _____		3l. HUMAN SUBJECTS RESEARCH REQUIRING IRB REVIEW/APPROVAL <input type="checkbox"/> YES <input type="checkbox"/> NO		3m. OTHER FUNDING <input type="checkbox"/> I am \ <input type="checkbox"/> I am NOT . . . currently seeking funds from other sources for this or other projects. <input type="checkbox"/> I am \ <input type="checkbox"/> I am NOT . . . currently receiving support from other sources for this or other projects.		
3n. PERCENT OF TIME TO BE SPENT ON RESEARCH TRAINING: _____ % <i>(required ONLY for Fellowships)</i>						
4a. NAME OF SPONSORING INSTITUTION			4b. SPONSORING DIVISION OR DEPARTMENT			
4c. DERMATOLOGY DEPARTMENT CHAIR OR DIVISION CHIEF Name _____ Title _____ Address _____ Tel _____ E-mail _____			4d. MENTOR* Name _____ Title _____ Address _____ Tel _____ E-mail _____			
4e. DERMATOLOGY CHIEF OF SERVICE (If not mentor.)* Name _____ Title _____ Address _____ Tel _____ E-mail _____			4f. FISCAL OFFICER Name _____ Title _____ Address _____ Tel _____ E-mail _____			
4g. INSTITUTIONAL OFFICER (Dean or designated official.) Name _____ Title _____ Address _____ Tel _____ E-mail _____			5a. DERM. DEPT. CHAIR OR DIV. CHIEF SIGNATURE / DATE _____/_____ 5b. INSTITUTIONAL OFFICER SIGNATURE / DATE _____/_____			
5c. APPLICANT SIGNATURE / DATE "I certify that the statements in this application are true to the best of my knowledge. In the event that I receive simultaneous salary funds from any federal agency or research funds from any other source, as defined in the award eligibility requirements, I understand that my Dermatology Foundation award will be terminated as of the day I begin to receive such funds. I agree to immediately notify the Foundation in writing upon notification of another award. I agree that that salary/research funds awarded to me will only be used for the project/purpose stated in my application. Any unused funds will be returned to the Foundation. I hereby agree to provide a written progress report and financial report to the Foundation within 30 days of the termination of the award." _____/_____						

* See instructions. Not required for all awards