

AMERICAN DERMATOLOGICAL ASSOCIATION



ANNOUNCEMENT AND APPLICATION

2009 MEDICAL STUDENT FELLOWSHIP PROGRAM

GENERAL INFORMATION AND REQUIREMENTS

The American Dermatologic Association is pleased to announce its 2009 Medical Student Fellowship Program offering:

- \$700 monthly stipend for a maximum of three (3) months
- Awards to start June 1, 2009

Preference will be given to applicants seeking to work in a department or division of dermatology. The work undertaken must be done at a university or college in the United States or Canada. Work done and research experience gained by recipients cannot be used as a credit for a degree. Awards will be made to U.S. citizens or Canadian citizens or candidates lawfully admitted to U.S. or Canada for permanent residence.

Applications relating to proposed research involving human subjects must be accompanied by institutional approval of the type required by the U.S. Public Health Service.

An original application and six (6) copies (7 total) of this application must be submitted. Any applications received without these copies will not be considered. This application must be signed by the sponsor and department chairperson unless they are one and the same.

A follow-up report of approximately 1 to 2 pages (not a manuscript for publication) is required within forty-five (45) days following completion of fellowship. Failure to comply will forfeit future awards to applicants from the sponsoring institution. Except under extraordinary circumstances, no more than one award will be granted to any school. Therefore, department chairpersons should assign priority ranking if more than one application is submitted.

Application Deadline:

April 15, 2009 (Applications received after this date will not be considered)

Applications, inquires and correspondence should be mailed to:

American Dermatological Association, Inc.
Attn: Julie Odessky , Executive Manager
P. O. Box 551301
Davie, FL 33355
Phone: 954-452-1113 Fax: 305-945-7063
Email: ameriderm1930@aol.com



**APPLICATION FOR
AMERICAN DERMATOLOGICAL ASSOCIATION
MEDICAL STUDENT FELLOWSHIP
2009**

(Please print or type)

1. Project Title _____
2. Name of applicant _____
3. Social Security Number _____
4. Current mailing address:

Telephone: _____

Email: _____

5. Permanent address:
- _____
- _____
- _____

Telephone: _____

6. Date of birth ____/____/____ I am a citizen of U.S. _____ Canada _____
7. I am a citizen of _____, but admitted to U.S. or Canada for permanent residence.
8. Degrees received with dates and schools _____

9. Attach a copy of previous publications (do not exceed five)

**Complete all requirements and return application by April 15, 2009 to:
American Dermatological Association, Inc.
P. O. Box 551301
Davie, FL 33355**

10. Names of:
Sponsor (mentor) _____
Department/Laboratory _____
Medical School/Hospital _____
Address: _____

Telephone: _____
Email: _____

11. Name of department chairperson _____
Address: _____

12. Names of school presently attending _____
Class _____ Anticipated date of graduation _____

13. Date of planned investigation (any curriculum-free three-month period):
From _____ To _____
month, day, year month, day, year

14. Make check payable to (name of applicant or institution).

15. Address of applicant or institution to whom the check should be mailed. If check is payable to institution, please include name and title of fiscal officer to whom check should be mailed.

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Davie, FL 33355**

16. **Description of proposed investigation and your role in the investigation:**
(Type or print. Do not exceed space provided except as may be required for
bibliography and staple to the last page. **Note that the readers of this application
are dermatologists.**)

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Davie, FL 33355

17. Does this project involve human or animal subjects? ___ yes ___ no

If yes, provide the date and proof of IRB approval. _____

If IRB approval is pending, provide date that the protocol will be/ was submitted. _____

18. **Applicant's verification**

_____ Space limitation requires that I attach an additional sheet for the bibliography. I have identified the attachment with my name and project title.

_____ I am ___ am not ___ applying for other funding for this student fellowship. (If additional funding is being sought, please give source of funding):

_____ I certify that to the best of my knowledge all of the submitted information relating to this application is true and correct. I shall abide by the stated requirements and by the regulations of by parent institution regarding clinical and investigative studies.

_____ I hereby agree to provide a follow-up report of (approximately 1 to 2 pages) to the American Dermatological Association within forty-five (45) days of the completion of my fellowship.

Applicant's Signature _____ Date: _____

Please print full name _____

19. **Sponsor:** I have reviewed this medical student fellowship application and have agreed to serve as the sponsor of the applicant.

Sponsor's Signature _____ Date: _____

Please print full name _____

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Davie, FL 33355**

20. **Department Chairperson (if different):** I have reviewed this medical student fellowship application and agree that the student fellowship can be done in my department under the above sponsorship.

Department Chairperson's

Signature _____

Please print full name _____ Date: _____

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Davie, FL 33355