# 2019 UROLOGY CARE FOUNDATION
# RESIDENCY RESEARCH AWARD
# APPLICATION AGREEMENT FORM

Your application for Urology Care Foundation funding will not be accepted or reviewed until this two-page form is completed and uploaded into the proposal submission portal. **Any forms received after 5:00 p.m. EASTERN time on Thursday, January 20, 2019 will not be accepted.** Please type all responses except where signatures are requested.

Applicant Name including degrees:

_____

Mentor Name(s):

PRIMARY Mentor including degrees:

_____

Mentor 2 including degrees:

_____

Mentor 3 including degrees:

_____

Research Institution: _____

_____

## APPLICANT SECTION

I certify that the statements and information included in my application and on this agreement form are true and complete to the best of my knowledge. If named a Urology Care Foundation Residency Research Awardee, I agree to complete my research project according to the guidelines as described in the 2019 Program Announcement, including:

1) Devoting a minimum of 80% effort to the research project during the award period.

2) Acknowledging the Urology Care Foundation program and the sponsor in any publication arising from work supported by the Urology Care Foundation Residency Research Award.

3) Notifying the AUA Office of Research in writing of any mailing or email address change, receipt of additional funding, change in project status, or change in mentor and/or personnel involved in the project before or during the award period of performance.

4) Attending all required AUA Office of Research research-related activities.

I am applying for a Urology Care Foundation Residency Research Award to be provided for the period of (choose one):

_____ One-year award: August 1, 2019 – July 30, 2020

_____ Six-month award: August 1, 2019 – January 31, 2019

_____ Six-month award: February 1, 2020 – July 30, 2020

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*Applicant Signature* *Date*

## MENTOR SECTION: PART A

I certify that the information included in this agreement form and the above-mentioned candidate's application is complete and true to the best of my knowledge. I agree to provide all necessary support for the duration of the award and abide by the reporting requirements of the program. I understand that if the candidate receives a Urology Care Foundation Residency Research Award, he or she must perform the research as stipulated in the specific program and maintain at least 80% level of effort for the duration of the residency research period. I also agree to adhere to the financial reporting requirements of the program, which include periodic re-affirmation of institutional support and level of effort.

| | | |
|---|---|---|
| *Primary Mentor Signature* | *Name (Printed)* | *Date* |
| *Mentor Signature* | *Name (Printed)* | *Date* |
| *Mentor Signature* | *Name (Printed)* | *Date* |

## MENTOR SECTION: PART B

**To Be Completed By The Primary Mentor Only**: As requested within the 2019 Program Announcement, please describe your involvement in the development of this application (i.e., the extent to which you provided guidance and mentorship to support the applicant).

## SPONSORING INSTITUTION SECTION: PART A

On behalf of the above listed institution, I agree to the guidelines as described in the 2019 Program Announcement, including the distribution and cost-matching of cost-sharing of funds as described in the Program Announcement. I agree that the institution will provide adequate support to this candidate including an appropriate research and training environment, laboratory equipment, and supplies to perform the proposed research and development of the trainee. The institution recognizes that the Urology Care Foundation does not withhold taxes from the award (i.e., federal withholding, social security, local taxes, etc.). I agree that under no circumstances should Urology Care Foundation funds or the designated institutional cost-matching or cost-sharing funds be used for institutional indirect costs or for salary support for anyone other than the Urology Care Foundation-funded resident. I also agree that the institution will adhere to the financial reporting requirements of the program, which include periodic re-affirmation of institutional support and level of effort.

_____

*Signature of Institution Representative* *Name (Printed)* *Date*

## SPONSORING INSTITUTION SECTION: PART B

Institution Tax ID#_____

Please provide contact information for a designated grant administrator at your institution. Any administrative inquiries and future payments will be directed to this individual. **PLEASE TYPE ALL RESPONSES.**

Name: _____

Title: _____

Street Mailing Address (**no P.O. Boxes**):

_____

_____

_____

City_____State_____Zipcode_____

Phone: _____Fax: _____

E-mail: _____