2019 UROLOGY CARE FOUNDATION
SUMMER MEDICAL STUDENT FELLOWSHIP PROGRAM
APPLICATION AGREEMENT FORM

Your application for Urology Care Foundation funding will not be accepted or reviewed until this three-page form is completed and submitted with the proposal. **Any forms received after 5:00 p.m. Eastern time on Thursday, January 10, 2019 will not be accepted.** Please type or print legibly. **NOTE: All mentors listed on the project must sign.**

Applicant Name: _____

Mentor Name(s) and Degree(s): _____

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 recipient of this award, I agree to abide by all guidelines as described in the Program Announcement. I understand that payment of the salary stipend will be made directly to me and that the Urology Care Foundation does not withhold taxes from the award (i.e., federal withholding, social security, local taxes). The Urology Care Foundation will provide an IRS 1099 form, if applicable, and I will be responsible for filing any and all taxes.

If named a Urology Care Foundation Summer Medical Student Fellow, I agree to complete my research project according to the guidelines as described in the 2019 Program Announcement, including:

1) Acknowledging the Urology Care Foundation and corresponding sponsor in any publication arising from work supported by the fellowship.

2) Notifying the AUA Office of Research in writing of any address change, receipt of additional funding, change in project status, or change in personnel involved in the project before or during the award period of performance.

3) Notifying the AUA Office of Research if I plan to attend any Urology Care Foundation research-related activities.

_____

Applicant Signature *Date*

MENTOR SECTION

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 Summer Medical Student Fellowship, he or she must dedicate 100% effort towards performing the research as stipulated in the application. **NOTE: All mentors listed on the project must sign.**

Mentor Signature	*Name (Printed)*	*Date*
Mentor Signature	*Name (Printed)*	*Date*
Mentor Signature	*Name (Printed)*	*Date*

SPONSORING INSTITUTION SECTION

On behalf of the above listed institution, I agree that the institution will provide adequate support to this candidate including an appropriate research and training environment, laboratory equipment, and supplies. The institution recognizes that the Urology Care Foundation does not withhold taxes from the award (i.e., federal withholding, social security, local taxes). I also understand that any funds for this award may not be used for institutional indirect costs.

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

Institution Tax ID#_____

Please provide contact information for a designated grant administrator at the institution. Any administrative inquiries will be directed to this individual. PLEASE PRINT OR TYPE.

Name: _____ Title: _____

Street Address: _____ Phone: _____

_____ Email: _____

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