

**2021 UROLOGY CARE FOUNDATION
SUMMER MEDICAL STUDENT FELLOWSHIP PROGRAM
PROPOSAL AGREEMENT FORM**

Your proposal for Urology Care Foundation funding will not be accepted or reviewed until this two-page form is completed and submitted with the proposal. **Any forms received after 5:00 p.m. Eastern time on Thursday, January 7, 2021 will not be accepted.** Please type or print legibly. **NOTE: All mentors listed on the project must sign.**

Applicant Name: _____

Primary Mentor Name and Degree(s): _____

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

Research Institution: _____

APPLICANT SECTION

I certify that the statements and information included in my proposal 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 2021 Program Announcement, including:

- 1) Acknowledging the Urology Care Foundation and corresponding sponsor in any publication arising from work supported by the fellowship.
- 2) Timely submission of satisfactory reports on the conduct and completion of my research project.
- 3) 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.
- 4) 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 proposal 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 proposal. **NOTE: All mentors listed on the project must sign.**

Primary Mentor Signature

Name (Printed)

Date

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 Institutional 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: _____
