

**2023 UROLOGY CARE FOUNDATION
SUMMER MEDICAL STUDENT FELLOWSHIP PROGRAM
PROPOSAL AGREEMENT FORM**

Your proposal for Urology Care Foundation funding will not be accepted unless this two-page form is completed in full and submitted with the proposal before the application deadline of **5:00 p.m. Eastern time January 5, 2023**.

Applicant Name and Degree(s): _____

Applicant Medical School: _____

Expected Graduation Date : _____

Fellowship Host Institution: _____

APPLICANT SECTION

I certify that the statements and information included in my proposal and on this form are true and complete to the best of my knowledge. 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 Program Announcement, including:

1. Maintaining 100% dedicated effort to the approved project.
2. Completing the required research duration of no less than 50 consecutive business days.
3. Acknowledging the Urology Care Foundation and corresponding sponsor in any publications and/or presentations arising from work supported by the fellowship.
4. Timely submission of satisfactory reports on the conduct and completion of my research project.
5. Immediately notifying the AUA Office of Research in writing of any receipt of additional funding during the project period, change in project status, or change in personnel involved in the project before or during the award performance period.
6. Notifying the AUA Office of Research if I plan to attend any Urology Care Foundation research-related activities.

Applicant Signature

Date

MENTOR(S) 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 the reporting requirements detailed in the Program Announcement. 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 for a minimum duration of 50 consecutive business days. **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

HOST INSTITUTION REPRESENTATIVE 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 while hosting them during the fellowship. I understand that funds for this award are paid directly to the awardee and may not be used for institutional indirect costs and/or costs for any personnel other than the award recipient. **NOTE: The Department Chair or Division Chief of the institution hosting the fellowship may serve as the signing representative.**

Signature of Institutional Representative

Name (Printed)

Date