

CHICAGO DERMATOLOGICAL SOCIETY

RESEARCH GRANT APPLICATION

TITLE OF GRANT PROPOSAL: _____

Amount Requested: \$ _____

APPLICANT INFORMATION

Name: _____

Date of Birth: _____

Current mailing address: _____

Telephone (Office): _____ (Home): _____

Fax: _____ E-mail: _____

Position: _____
Current during Period of Proposed Support

- CDS Member* *Resident or Fellow in Training*
 Non-member dermatologist

PENDING SUPPORT

List other pending applications or funds received from any source for financial support of the program or project and indicate amounts.

Source: _____ Amount: \$ _____

Source: _____ Amount: \$ _____

Source: _____ Amount: \$ _____

BUDGET DATA

Provide a detailed budget as a separate attachment. Include a concise statement of how you propose to allocate funds (amount and for what purpose). Separately list each item of equipment with a unit acquisition cost of \$500 or more. Itemize supplies such as glassware, chemicals, and animals in separate categories. If animals are involved, state how many are used, their unit purchase cost, and their unit care cost. Clinical investigators should submit details of projected costs for laboratory tests, biopsies, medications, and related items. Summarize budget below.

BUDGET SUMMARY

	<i>Grant Funds</i>	<i>Matching Funds</i> <small>(if any)</small>	<i>Total</i>
Equipment (non-expendable)	_____	_____	_____
Supplies (expandable)	_____	_____	_____
Other	_____	_____	_____
Total	_____	_____	_____

INSTITUTIONAL DATA

Name of Institution: _____

Location: _____

Sponsoring Department, Service, Laboratory, or equivalent: _____

Preceptor of Sponsoring Department: _____

Address: _____ Telephone: _____

Head of Sponsoring Department: _____

Address: _____ Telephone: _____

Dean or Administrative Official

Title: _____

Address: _____ Telephone: _____

Fiscal Officer (to whom check will be made):

Title: _____

Address: _____ Telephone: _____

IRB Administrative Official _____

IRB Project Number _____ **Approval Status** _____

Signature of Applicant

Date

Signature of Preceptor

Date

Signature of Department Head

Date

Signature of Dean or Administrative Official

Date

"I certify that the statements in this application are true to the best of my knowledge. In the event that I receive simultaneous funds from other sources (except departmental funds of my sponsoring institution or National Institutes of Health training grants), I understand that my grant will be terminated as of the day I begin to receive such funds. I agree to immediately notify the Chicago Dermatological Society in writing and will return any unused award funds. I hereby agree to provide a written progress report to the Chicago Dermatological Society within 60 days prior to the termination of the grant."

Signature of Applicant

Date

NOTE: APPLICATIONS WILL NOT BE PROCESSED UNLESS ALL COMPONENTS HAVE BEEN COMPLETED AND SUBMITTED WITH ANY REQUIRED SUPPORTING MATERIALS BY THE DEADLINE.
NO APPLICATIONS WILL BE RETURNED FOR CORRECTION OF DEFICIENCIES AND RESUBMISSION