

GRANT CYCLE:

TITLE OF GRANT PROPOSAL:

**APPLICANT INFORMATION** 

Date of Birth (mm/dd/yyyy):

Current mailing address:

Telephone (Office):

Position: Current

OTHER SOURCES OF SUPPORT

program or project, and indicate amounts.

Fax:

E-mail:

Source:

Source:

Source:

Name (first/last/degree):

Amount Requested (maximum \$1000):

PGY-2

(check one)

Check one:

# CHICAGO DERMATOLOGICAL SOCIETY

# Research Grant Application **Resident Quality Improvement Award**

Amount: \$

v 08.2024 Fall/Winter Cycle Spring Cycle \$ PGY-3 PGY-4 (Mobile): During project timeframe List other pending applications or approved funds received from any source for financial support of this Amount: \$ Amount: \$

Continued next page

#### **BUDGET DATA**

Provide a detailed budget in a separate attachment. Include a concise statement of how you propose to allocate funds (i.e., 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**

	CDS Grant Funds	Matching Funds (if any)	Total
Equipment (non-expendable)	\$	\$	\$
Supplies (expandable)	\$	\$	\$
Other	\$	\$	\$
Total	\$	\$	\$

INSTITUTIONAL INFORMATION		
Name of Institution:		
Location (city/state):		
Sponsoring Department, Service, Labora	atory, 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 ser Title:	nt):	
Address:	-	Telephone:
Check should be made payable to:		
IRB Administrative Official: IRB Project Number:	Approval Status	

## **S**IGNATURES

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 knowle (except departmental funds of my sponsoring institution or National Institutes of H the day I begin to receive such funds. I agree to immediately notify the Chicago D I hereby agree to provide a written progress report to the Chicago Dermatological	ealth training grants), I understand ermatological Society in writing an	l that my grant will be terminated as o id will return any unused award funds
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 DATE.

APPLICATIONS WILL NOT BE RETURNED FOR CORRECTION OF DEFICIENCIES