DAMON RUNYON
CANCER RESEARCH
FOUNDATION

Physician-Scientist Training Award

At-a-Glance Form

APPLICANT'S NAME:	INSTITUTION:
ACADEMIC TITLE:	ARE YOU U.S. SPECIALTY BOARD ELIGIBLE? ☐ Yes ☐ No
DEPARTMENTAL AFFILIATION:	LIST YEARS OF FELLOWSHIP (*IF APPLICABLE*) :
HAVE YOU COMPLETED YOUR RESIDENCY AND CLINICAL TRAINING?: ☐ Yes ☐ No	WILL YOU DEDICATE 80% OF YOUR TIME TO CONDUCT RESEARCH? ☐ Yes ☐ No
HAS YOUR INSTITUTION GUARANTEED YOU 80% PROTECTED TIME TO CONDUCT YOUR RESEARCH? ☐ Yes ☐ No	LIST OTHER FUNDING SOURCES: *CURRENT (TERM):* *PENDING (ACTIVATION DATE):*
MENTOR'S NAME:	CO-MENTOR'S NAME *(IF APPLICABLE)*:
MENTOR'S ACADEMIC RANK:	CO-MENTOR'S ACADEMIC RANK *(IF APPLICABLE)*:
MENTOR'S DEPARTMENTAL AFFILIATION:	CO-MENTOR'S DEPARTMENTAL AFFILIATION *(IF APPLICABLE)*:
(*FOR THE APPLICANT*): PLEASE WRITE A PARAGRAPH DESCRIBING THE NATURE OF YOUR CLINICAL ACTIVITIES:	
PLEASE DESCRIBE YOUR PREVIOUS RESEARCH EXPERIENCE (STATE "NONE" IF NOT APPLICABLE):	