SOAR
Medical Student Research Funds Application

Applicant Information

Name: ____________________ Date of Request: ____________________

Home Address: ____
Number, Street Apt., Ste. # City State Zip

Phone: ____________________ Email: ____________________

Class Year: ____________________

Research Mentor Information

Mentor Name: ____________________ Mentor Department: ____________________ Mentor Email: ____________________

Conference Information

Conference Name: ____

Conference Date: ____________________

Conference Location: (City, State) ____________________

Expected Dates of Travel: ____________________

Anticipated Travel Costs:
- Registration ____________
- Transportation ____________
- Accomodation ____________
- Other ____________
- Total ____________

Educational Purpose: ____________________

Presentation Format: ____________________

If membership costs are requested please provide justification and amount. ____________________

Is this event related to a student organization:
If yes, please provide the name of the organization: Yes No ____________________

Are you receiving any additional funding support from BCM? (*For example, from a student organization or a department*) Yes No

If yes, please provide the following information:
Department name: ____________________
Contact person: ____________________
Email: ____________________

Please attach a copy of: 1) Letter of support from your research mentor; 2) Letter of approved course/clerkship absence from course/ clerkship director; 3) Letter of acceptance/invitation to participate in meeting/conference; 4) Conference abstract. When you are ready to submit, please send this application and supplemental documents as a single PDF to soar-office@bcm.edu. All SOAR resaerch must be conducted with a faculty member from BCM or an affiliated institution as your research mentor.

Office Use Only

Date application submitted ____________________ Reviewed by: ____________________

Approved: Yes No Funded: Yes No Amount Funded: __________ Date: __________