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: _____

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

Is this event related to a student organization: ☐ Yes ☐ No

If yes, please provide the name of the organization: _____

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.

Office Use Only

Date application submitted _____ Reviewed by: _____

Approved: ☐ Yes ☐ No Funded: ☐ Yes ☐ No Amount Funded: _____ Date: _____