

APPLICATION

R. CLIFTON BROOKS, JR MEDICAL RESEARCH FELLOWSHIP

Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Address:
Home: _____ Office: _____

Phone: _____
Area Code Area Code

Education:
High School: _____
Undergraduate: _____
Post Graduate: _____
Institution, City, State Degree/ Honors Major Area of Study Year Conferred

Post-doctoral Training: _____

Present Academic Affiliation: _____

Area of Research Interest: _____

This application must be accompanied by:

1. A copy of the Applicant's Curriculum Vitae.
2. Three letters of Reference regarding the Applicant's ability to conduct independent research, as well as his/her integrity, and dependability.
3. A letter of endorsement and support from the Department Chairman or equivalent administrator.
4. A summary of the research project that will be supported by this grant.
5. I will acknowledge the Brooks Fund and the Sons of Confederate Veterans (SCV) as the source of funding in any publications and presentations of the research results.
6. Documented proof of Confederate ancestry.

I attest that the above and enclosed information is true and accurate.

Applicant's Signature

Date

I hereby attest that the applicant named above is in good standing at this institution, and in the event of an award of the R. Clifton Brooks, Jr. Medical Research Fellowship, will have adequate opportunity to perform the research described herein.

Name (Print or Type)

Position/Institution

Administrator's Signature

Date

(To be signed by the appropriate Dean, Department Head, or Administrator of the Office of Research)

Applications are to be submitted to:

Ben M. Treen, MD
49 Foxchase Rd
Dothan AL 36305
(864) 295-3376
p-38@dermsurgeon.com