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| Burroughs Wellcome Fund  Investigators in the Pathogenesis of Infectious Disease  **SIGNATURE PAGE** | | |
| Title of Project: *(Text only; no special characters or formatting. Be sure to INCLUDE YOUR NAME with the project title, using this format: Last Name, First Name – Project Title)* | | |
| Applicant Name (Last, First): | Highest Degree: | |
| Title IF DIFFERENT FROM ASSISTANT PROFESSOR: | Applicant’s Current institution: | |
| Academic Rank: |
| Division: | Mailing Address: | |
| Department: |  | |
| Email Address: |  | |
| Tel: Fax: |  | |
| APPLICANT ASSURANCE:  I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application. | **SIGNATURE OF APPLICANT:**  Date: | |
|  | | |
| Accredited Degree Granting Institution: | | |
| Mailing Address: | | |
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| Tel: | Fax: | |
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| SIGNING OFFICIAL ASSURANCE:  I certify that the statements herein are true, complete, and accurate to the best of my knowledge, and accept the obligation to comply with the grantor’s terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to  Criminal, civil, or administrative penalties. | Signing Official Name: | |
|  | |
| Title: | |
| Institution: | |
| Address: | |
| Tel: | Fax: |
| **SIGNATURE OF SIGNING OFFICIAL:**  Date: | |