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)		
ADDUCANT NAME (LACT FIRST)	LUCUEST DECREE	
APPLICANT NAME (LAST, FIRST): TITLE IF DIFFERENT FROM ASSISTANT PROFESSOR:	HIGHEST DEGREE:	
TITLE IF DIFFERENT FROM ASSISTANT PROFESSOR:	APPLICANT'S CURRENT INSTITUTION:	
ACADEMIC RANK:		
DIVISION:	MAILING ADDRESS:	
DEPARTMENT:		
EMAIL ADDRESS:		
TEL: FAX:		
APPLICANT ASSURANCE:	SIGNATURE OF APPLICANT:	
<u> </u>		
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.		
		DATE:
ACCREDITED DEGREE GRANTING INSTITUTION:		
MAILING ADDRESS:		
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TEL:	FAX:	
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SIGNING OFFICIAL ASSURANCE:	SIGNING OFFICIAL NAME:	
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	TITLE:	
and conditions if a grant is awarded as a result of this application. I am aware	INSTITUTION:	
that any false, fictitious, or fraudulent statements or claims may subject me to		
Criminal, civil, or administrative penalties.		
	ADDRESS:	
	TEL:	FAX:
	SIGNATURE OF SIGNING OFFICIAL:	
		DATE: