JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP

2015 APPLICATION INSTRUCTIONS AND FORM

- The deadline for receipt of a completed application is December 23, 2014 for the award to become effective July 1, 2015. Exceptions to start date should be discussed with the TMA.
- All sections of the application form must be completed. Include the section number and heading/title on the top of the pages used to provide the information requested.
- Electronic submissions are preferred as one combined PDF document.
- Do not make any changes in the layout of the forms.
- Use standard size black type no smaller than 11 point; do not use photo reduction.
- Copies of any preprints, reprints, or other additional materials must be submitted with the application.
- **The application must be submitted accompanied by all supporting documents. Please do not submit your application until you have assembled all references, transcripts and other requested materials.**
- Letters of Recommendation: The letters should include one from the chairperson of your department or residency director and your mentor. Referees may directly email the letter of support to ckrishnan@myelitis.org.
- The application cannot be considered for review unless signed by the applicant, the mentor, and the authorized signatory of the sponsoring institution. "Per" signatures will be disallowed.
- The application and all correspondence relating to it must be received at the TMA by December 23, 2014 to be considered for a fellowship to begin July 1, 2015.
- For more about the goals of the Fellowship, please visit – http://myelitis.org/research/james-t-lubin-fellowship
- Please submit application electronically to ssiegel@myelitis.org and ckrishnan@myelitis.org

If you have any questions about the preparation of your application, please contact

Sanford Siegel | ssiegel@myelitis.org
Chitra Krishnan | ckrishnan@myelitis.org

THE TRANSVERSE MYELITIS ASSOCIATION

www.myelitis.org
info@myelitis.org

JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP APPLICATION

I. APPLICANT

FIRST _____ MIDDLE _____ LAST _____

DEGREES _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

TEL. _____ FAX _____

EMAIL ADDRESS _____

II. MENTOR

FIRST _____ MIDDLE _____ LAST _____

DEGREES _____

POSITION _____

ORGANIZATION _____

DEPARTMENT _____

INSTITUTION _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

TEL. _____ FAX _____

EMAIL ADDRESS _____

III. PROPOSED TRAINING INSTITUTION

INSTITUTION _____

DEPARTMENT _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

TEL. _____ FAX _____

EMAIL ADDRESS _____

THE TRANSVERSE MYELITIS ASSOCIATION

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IV. DEPARTMENT CHAIR

NAME _____

POSITION _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

TEL. _____ FAX _____

EMAIL ADDRESS _____

V. DIRECTOR OF SPONSORED RESEARCH

NAME _____ DEGREES _____

POSITION _____

ORGANIZATION _____

DEPARTMENT _____

SCHOOL _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

TEL. _____ FAX _____

EMAIL ADDRESS _____

VI. INSTITUTION'S FINANCIAL OFFICER

NAME _____

POSITION _____

DEPARTMENT _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

TEL. _____ FAX _____

EMAIL ADDRESS _____

VII. PAYMENT INFORMATION

Award Checks Payable To:

VIII. FELLOWSHIP AWARD

The fellowship award is payable to the institution on a quarterly basis, to cover the fellow's salary and fringe benefits through a grant agreement. Please refer to the TMA's Guidelines for Funding and Public Access Policy for information concerning allowable expenses and other instructions concerning the preparation of your budget. No indirect costs or other institutional taxes will be covered by the fellowship per the policies and practices of the TMA. A letter must be attached from the mentor's institution confirming that the institution has committed to supporting the remaining costs for the fellow candidate, including but not limited to the cost for malpractice insurance, any salary augmentation and a benefits package. These itemized costs should be disclosed in the letter.

JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP APPLICATION

IX. BIOGRAPHICAL SKETCH OF APPLICANT | PRINCIPAL INVESTIGATOR

Please attach your biographical sketch in NIH format or use the format below.

i. Education

Include undergraduate, graduate/medical school, internship and residency

Name and Location of Institution Inclusive Dates Degrees Earned

ii. Academic Honors

Include dates

iii. Professional Experience

Begin with most recent position

Position Employer Name and Location Inclusive Dates

iv. Membership in Professional Organizations

Include dates

v. Applicant's Bibliographic Citations

Include complete reference and list in chronological order

X. PERSONAL STATEMENT

Describe your long and short-term career goals. Discuss how the fellowship will advance these goals. Be sure to address how your career goals relate to clinical care and research in the rare neuro-immune diseases. Describe your personal qualifications for this award. (Please limit to one page).

XI. CLINICAL TRAINING PLAN

Using the following outline, describe the training plan that you and your mentor have developed to meet the required components of training. Please limit to two pages.

Components of Training:

1. *Direct, supervised ADEM, NMO, ON and TM patient care (60%)*
2. *Exposure to multidisciplinary care (20%)*
3. *Didactic activities (10% - including producing a clinical paper, attending lectures grand rounds, etc.)*
4. *Other (10%) please specify:*

JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP APPLICATION

XII. RESEARCH TRAINING PLAN

Describe the training plan that you and your mentor have developed to meet the required components of training. Please limit to two pages.

XIII. RESEARCH PROJECT INFORMATION

PROJECT START DATE _____

PROJECT END DATE _____

Please check all categories that apply to your proposal:

- ☐ HUMAN SUBJECTS
- ☐ HUMAN TISSUES
- ☐ HUMAN CELL LINES
- ☐ HUMAN FETAL TISSUE / STEM CELLS

Has this project been submitted to or will it be submitted to another agency?

- ☐ YES
- ☐ NO

If you answered yes, please identify the name of the agency:

_____

XIV. HUMAN SUBJECTS AND/OR VERTEBRATE ANIMALS

The applicant institution has the primary responsibility for protecting the rights and welfare of human subjects and for ensuring the humane care and use of animals in all research activities supported by The Transverse Myelitis Association and of informing the TMA of all relevant assurances and certifications. If an award is made as a result of this application, it is the responsibility of the grantee or fellow and the Institution to inform the TMA within a reasonable time of any change in the research protocol.

By virtue of the signature of an official authorized to sign for the institution on this application, the institution is declaring that all applicable Federal, State and Local regulations will be followed during the tenure of any grant awarded as a result of this Application. This form must be completed and submitted with any application to the TMA for the support of research or training. In addition, a copy of the approval letters signed by the Chairperson of the Institutional Review Board (IRB) and/or the Institutional Animal Use and Care Committee, as appropriate, must accompany any application. No funds will be dispersed for any award until these materials have been received, reviewed and accepted by the TMA.

i. Human Subjects

Will Human Subjects be Used:

- ☐ YES
- ☐ NO

If the IRB review is pending, approval must be obtained and evidence of approval submitted to the TMA prior to funding. If IRB approval has been granted, a copy of the approval letter must be submitted as part of the PDF file that is uploaded in the Letters section.

IRB APPROVAL _____

IF EXEMPT, PROVIDE REASON _____

APPROVAL DATE _____ EXPIRATION DATE _____

IRB PROTOCOL NUMBER _____

The Assurance of Compliance Number issued to the applicant institution by the Federal Office of Protection from Research Risks: xc549863

ASSURANCE OF COMPLIANCE NUMBER _____

ii. Vertebrate Animals

Will Vertebrate Animals be Used:

- ☐ YES
- ☐ NO

If the review is pending, approval must be obtained and evidence of approval submitted to the TMA prior to funding. If approval has been granted, a copy of the approval letter must be submitted as part of the PDF file that is uploaded in the Letters Section.

Institutional Animal Care and Use Committee Approval:

APPROVAL DATE _____ EXPIRATION DATE _____

APPROVAL NUMBER _____

ANIMAL WELFARE ASSURANCE NUMBER _____

XV. LAY LANGUAGE SUMMARY OF PROPOSED PROJECT

Please provide a summary of your proposed research in language suitable for a news release to the lay public. Please limit your summary to 500 words or less.

XVI. SCIENTIFIC SUMMARY OF PROPOSED PROJECT

Please provide a summary of the proposed research. Please limit your summary to 500 words or less. Be certain to address the relevance of the project to ADEM, NMO, ON and/or TM.

XVII. OTHER SUPPORT

Use the format below to list current and pending support for the principal investigator and mentor. Show the agency to which the application(s) was/were submitted (for NIH, include the institute and grant number) indicate the title of each project, its duration, and the percent effort of the individual. This listing should include support from all sources including governmental, non-profit, foundation, private philanthropic and other sources. Briefly describe the specific aims of each project and how they relate to this project. List the support in US dollars for the current year and the total support in US dollars for all years.

i. Title of Project

ii. Status

iii. Name of Professional

iv. Support for Current Year $

v. Total Support for All Years $

vi. Start Date

vii. End Date

viii. Percent Effort

ix. Specific Aims

x. Funding Agency

JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP APPLICATION

XVIII. REFERENCE LETTERS

One of the letters of support must be from the Dean or the Chairperson of the Department or authorized official of the sponsoring institution acknowledging support for employment of the individual for 2 years, for additional salary support to the individual as necessary, the commitment to protect at least 70% of the candidates time for clinical care/clinical research/basic science research of rare neuro-immune diseases (general neurology clinic or inpatient service are excluded from the 70% commitment), and support for the applicant covering additional costs, such as for malpractice insurance and fringe benefits.

The letter must also address each of the following issues:

1. *What makes the applicant an ideal candidate for this competitive fellowship,*
2. *How the fellowship fits into the long-term goals of having the candidate become a future leader in the field of neuro-immune diseases, such as TM, NMO and ADEM,*
3. *Why the fellowship is important for the applicant at this point in their career.*

Instructions: *Provide three reference letters from people other than your mentor. They may be attached as a PDF or emailed directly to ckrishnan@myelitis.org*

Reference 1

NAME _____

TITLE _____

ASSOCIATED ORGANIZATION _____

MAILING ADDRESS _____

PHONE NUMBER _____

EMAIL _____

Reference 2

NAME _____

TITLE _____

ASSOCIATED ORGANIZATION _____

MAILING ADDRESS _____

PHONE NUMBER _____

EMAIL _____

JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP APPLICATION

Reference 3

NAME _____

TITLE _____

ASSOCIATED ORGANIZATION _____

MAILING ADDRESS _____

PHONE NUMBER _____

EMAIL _____

XIX. MEDICAL SCHOOL TRANSCRIPTS

Scanned originals or photocopies are acceptable

Name of Institution Address

XX. MENTOR'S BIOGRAPHICAL SKETCH AND PROFESSIONAL EXPERIENCE

Provide mentor's biographical sketch including bibliographical citations in NIH format as an attachment.

XXI. LETTER OF SUPPORT FROM MENTOR

The mentor must provide the following information. The mentor letter must be attached to this application:

1. *A description of the ongoing clinical activities at the MS clinic or practice.*
2. *A description of the multidisciplinary care team.*
3. *A description of any previous or current fellowship/trainees in the past 5 years.*
4. *An evaluation of the likelihood that the applicant will make a meaningful contribution to ADEM, NMO, ON and TM as a clinician after the fellowship training.*

XXII. MENTOR'S TRAINING EXPERIENCE

Please use the format below to list current and previous fellows/trainees for the past 5 years

i. Trainee

ii. Level of Training

iii. Dates

iv. Present Position

XXIII. LETTERS SUBMITTED WITH APPLICATION

PDF Format

- *Letters of Collaboration*
- *Approval Letters for use of human subject and/or animals (section XII)*
- *Three Reference Letters (section XVI)*
- *Mentor Letter of Support (section XIX)*

XXIV. MATERIALS SUBMITTED WITH APPLICATION

PDF Format

- *Applicant's Biographical Sketch (section IX)*
- *Personal Statement (section XI)*
- *Clinical Training Plan (section XI)*
- *Research Training Plan (section XII)*
- *Lay Language Summary of Proposed Project (section XV)*
- *Scientific Summary of Proposed Project (section XVI)*
- *Other Support (section XVII)*
- *Medical School Transcripts (section XIX)*
- *Mentor's Biographical Sketch and Professional Experience (section XX)*
- *Mentor's Training Experience (section XXII)*

JAMES T. LUBIN CLINICIAN SCIENTIST FELLOWSHIP APPLICATION

Applicant's full name and Degree(s)

CERTIFICATE OF APPLICANT AND SPONSORING INSTITUTION

By the act of submitting an application for an award, it is agreed by the Applicant and the Institution that: 1) Funds awarded as a result of this request are to be expended for the purpose(s) set forth herein and in accordance with the policies and procedures set forth by The Transverse Myelitis Association; 2) The information herein is true and complete to the best of our knowledge; 3) The Award may be revoked in whole or in part at any time by the TMA, provided that a revocation shall not include any amount obligated previous to the effective date of revocation if such obligation were made solely for the purposes set forth in this application; 4) All reports of activities supported by any award made as a result of this request shall acknowledge such support.

Name	Signature	Date	Office Telephone No.
Applicant:		_____	
Mentor:		_____	
Financial Officer:		_____	
Official Authorized to Sign for Institution [include official's title]:		_____	