2024 Diversity Research Supplement Award

Medical Student Eligibility Form

The Dermatology Foundation is pleased to offer the Diversity Research Supplement Award (DRSA) -- a research award developed to enhance diversity in dermatology and the specialty's academic workforce.

The DRSA provides funding to support the in-depth participation of a full-time medical student considered underrepresented in biomedical research. This includes, but is not limited to, individuals who identify as belonging to ***specific racial or ethnic minority***, ***sexual or gender minority,*** or ***other disadvantaged groups***. The applicant for a DRSA is a project mentor who is a current or recent recipient of a DF career development award.

To be considered for a DRSA, you must complete, sign and return a copy of this form to the project mentor. The completed form will also be shared with the DF (including its staff and members of its oversight committee.) Please complete the form and return it to the project mentor in a pdf format bearing your original signature.

Full Name: _____

Degrees: _____

Year of Birth: _____

Email Address: _____

Medical School/Institution: _____

Expected Date of Graduation: _____

The following questions are derived from the NIH definitions for individuals who are considered underrepresented in biomedical research. The DF will review your answers and information provided to determine your eligibility for the DRSA program. In addition, the DF will deidentify the information collected, aggregate it with information provided by other students and use it to measure the impact of the DRSA program over time. All information collected will be retained and used in accordance with the DF's Privacy Policy and as described herein.

Providing the following information is optional. However, the application may be declined if insufficient information is provided to confirm your eligibility for this program.

1. **Race and Ethnicity**: Please check all that apply.

____ Black or African American
____ Hispanic or Latino
____ American Indian or Alaska Native
____ Native Hawaiian or Pacific Islander
____ White
____ Asian
____ Prefer not to disclose

2. Gender Identity and Sexual Orientation:

Gender Identity -- ***Do you think of yourself as:***

____ Male
____ Female
____ Transgender man/trans man
____ Transgender woman/trans woman
____ Genderqueer/gender nonconforming neither exclusively male nor female
____ Other please specify _____
_____
____ Prefer not to disclose

Sexual Orientation -- Do you think of yourself as:

____ Straight or heterosexual
____ Lesbian or gay
____ Bisexual
____ Queer, pansexual, and/or questioning
____ Something else; please specify
____ Don't know
____ Prefer not to disclose

3. Experiences of disadvantage: Please check all that apply to you.

____ Were or currently are homeless
____ Were or currently are in the foster care system
____ Were eligible for the Federal Free & Reduced Lunch program for 2 or more years
____ Have/had no parents or legal guardians who completed a bachelor's degree
____ Were or currently are eligible for Federal Pell grants
____ Received support from the Special Supplemental Nutritional Program for Women, Infants & Children
____ Grew up in a US rural area, as designated by the Health Resources and Services Admin. Rural Health Grants Eligibility Analyzer or a Centers for Medicare & Medicaid Services-designated Low-Income and Health Professional Shortage Area
____ Other circumstance, please specify: _____
_____
____ None of the above statements apply
____ Prefer not to disclose

Medical Student Certification

I certify that the information I have provided on this form is true and may be used by the Dermatology Foundation for the purposes described herein.

Signature: _____ **Date:** _____

Please provide original signature.

8/23