



2025 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.

- | | |
|--|---|
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Prefer not to disclose |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | |

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.