2025 Medical Student Research Supplement Award

Medical Student Demographics Form

The Dermatology Foundation is pleased to offer the Medical Student Research Supplement Award (MSRSA), a research award developed to enhance medical student research participation in the field of dermatology and the specialty's academic workforce.

Each MSRSA award is intended to support the in-depth participation of a full-time medical student who may be a member of the following groups but is not limited to: racial or ethnic minorities, sexual or gender minorities, or other underserved or disadvantaged populations.

The applicant for an MSRSA is a project mentor who is a current or recent recipient of a DF career development award.

As part of your MSRSA application, please complete the demographics form and include it with your online application, bearing your original signature.

Full Name: _____

Degrees: _____

Year of Birth: _____

Email Address: _____

Medical School/Institution: _____

Expected Date of Graduation: _____

The following demographic questions are derived from the NIH definitions for individuals who are considered underrepresented in biomedical research. The DF will de-identify the information collected, aggregate it with details provided by other students, and use it to measure the impact of the MSRSA program over time. All collected information will be retained and utilized in accordance with the DF's Privacy Policy and as described herein.

Providing the following information is optional.

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 accurate and may be used by the Dermatology Foundation for the purposes described herein.

Signature: _____ **Date:** _____

Please provide your original signature.