UNIVERSITY OF ALBERTA

MD/PHD & MD/MSc STUDENT CONFIRMATION OF ELIGIBILITY FORM

Student name: **Student ID:**

For completion by student:

- ☐ I am registered full-time (Fall, Winter, Spring, and Summer terms) in the graduate portion of the MD/PhD or MD/MSc program.
- ☐ I will hold full-time graduate registration during the term of payment of the award.
- ☐ The Office of Research must be informed if the student no longer holds full-time graduate registration so that award payments can be terminated.
- ☐ I agree to notify the Office of Research (fmdgrd@ualberta.ca) in writing if I no longer meet the award's eligibility criteria.

The **[MD/PhD or MD/MSc Program]** confirms the eligibility of **[student name]** for the Faculty of Medicine and Dentistry scholarships.

_____ _____
Student signature Date

_____ _____
MD/PhD Program Director Date

College of Health Sciences
Faculty of Medicine & Dentistry
Office of Research

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