Boston University School of Medicine
Division of Graduate Medical Sciences
72 East Concord Street, Room L-317
Boston, Massachusetts 02118
T 617-638-5255 F 617-638-5740

M.D./Ph.D. SUMMER ROTATION & STIPEND AGREEMENT FORM (8-10 Week Rotation)

I will work with _____ for 8-10 weeks from _____
Principal Investigator/Supervisor's Name (PRINT) MM/DD/YEAR

to _____. After completing this rotation, and once the Division of Graduate Medical
MM/DD/YEAR

Sciences has received written notification from my principal investigator that I have fulfilled my responsibilities, I will be eligible for a $4,000 stipend. The $4,000 will be awarded only upon completion of this laboratory rotation. Laboratories, departments, or programs will not be permitted to supplement the stipend with additional funds.

_____
Student Name (PRINT)

Date of Birth: _____ Social Security #: _____

_____ _____
Student Signature Date

_____ _____
Principal Investigator/Supervisor Signature Date

_____ _____
MD/PhD Program Director Signature Date

Please return this completed form to the MD/PhD Administrative Coordinator, Division of Graduate Medical Sciences, L-317.

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M.D./Ph.D. SUMMER ROTATION & STIPEND COMPLETION FORM (8-10 Week Rotation)

This form verifies that _____ worked from _____
Student Name (PRINT) MM/DD/YEAR
to _____ on a 8-10 week rotation. This student has fulfilled their responsibilities
MM/DD/YEAR
and is eligible for a $4,000 stipend.

_____
Principal Investigator/Supervisor Name (PRINT)

_____ _____
Principal Investigator/Supervisor Signature Date

_____ _____
MD/PhD Program Director Signature Date

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