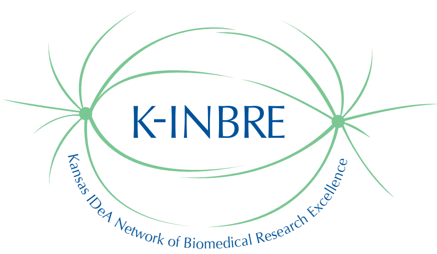

Partnering Program Application

Please complete and return to:
Attn: Heiata Chapman
University of Kansas Medical Center
Mail stop 3050
3901 Rainbow Blvd.
Kansas City, KS 66160
Phone# (913) 588-7170
Fax# (913) 588-7180
hchapman@kumc.edu

Today's Date ________

Visitor

Name ____________________

Home Address ____________________

City ____________________

State/Province ____________ Zip Code ________

Country ____________ Phone ________

E-mail ____________________

University ____________________

Home Address ____________________

City ____________________

State/Province ____________ Zip Code ________

Country ____________ Phone ________

Circle One Faculty Student

Host Faculty

Name ____________________

University ____________________

University Address ____________________

City ____________________

State/Province ____________ Zip Code ________

Country ____________ Phone ________

E-mail ____________________

Estimated Number of Days at Host Institution ________

Dates of Planned Visit ____________________

Reason for Scientific Visit

Reason for Scientific visit including a brief introduction of the project, a letter of support from the Host Faculty, and a written commitment to cite the NCRR (NIH) sponsored Kansas IDeA Network of Biomedical Research Excellence (P20 RR016475) in any publication or presentation forthcoming as a result of this visit. Students should provide a letter of support from their faculty mentor at the home institution.

Please attach all required materials: