



HANNAH DEVELOPMENT GRANT APPLICATION FORM

Development Grant

**The submission
deadlines are
March 1st, 2007
September 15th,
2007**

**Consult
Application Guidelines
before completion**

Development Grant support
is awarded for one year only

Renewal is by full application

Send application to:

Associated Medical
Services, Inc.
162 Cumberland Street
Suite 228
Toronto, Ontario
M5R 3N5

**APPLICATIONS
WILL NOT BE
ACCEPTED
BY FAX OR E-MAIL**

Revised August 2006

1 Application Category:		<input type="checkbox"/> New <input type="checkbox"/> Renewal
2 Principal Applicant Information		
Name		
Contact Address		
University/Organization Address (if different from above)		
Telephone:	FAX	E-mail
Citizenship: <input type="checkbox"/> Canadian <input type="checkbox"/> Permanent Resident in Canada		
Title and Affiliation or Employer		
3 Co-Investigators: List name, contact address and position on an attachment page		
4 Project Information		
Title of proposed project		
Start Date	End Date:	
5 Research Ethics Certificate required? <input type="checkbox"/> No <input type="checkbox"/> Yes Certificate attached <input type="checkbox"/>		
6 Budget Information		
Amount Requested from AMS	Total Estimated Cost	
7 Referees		
Name, Title and Affiliation	Specialist in field <input type="checkbox"/> Yes <input type="checkbox"/> No	Knows my work <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, Title and Affiliation	Specialist in field <input type="checkbox"/> Yes <input type="checkbox"/> No	Knows my work <input type="checkbox"/> Yes <input type="checkbox"/> No
8 Signatures		
Principal Applicant	Date	
Co-Applicant(s) (use attachment page if necessary)	Date	
Administering Institution (see below)	Date	
The application must be signed by the designated representative of the administering institution. In signing this application, the applicant and administering institution agree to abide by the AMS Terms and Conditions as outlined in the relevant 2007 AMS Program Guidelines.		
9 Contact information for the designated representative of the Administering Institution		
Name		
Title		
Phone number		

Complete mailing address