

ClinicalMind Scholarship for Black Pharmacy Students
Application Certification

APPLICANT

If I am awarded and accept an AFPE Fellowship, I agree:

1. To notify the Foundation immediately if I discontinue my studies for any reason.
2. To carry a full-time program of study throughout the term of my AFPE Fellowship.
3. Not to be employed full-time during the term of this Fellowship. This requirement does not exclude my acceptance of a part-time teaching or research assistantship or other part-time employment provided it does not significantly delay receipt of my PhD.
4. To notify AFPE if I am awarded any other external scholarships, fellowships and/or grants that overlap any portion of the term of my AFPE Fellowship. External funding is permitted.

DEAN OF PHARMACY

1. I have reviewed this application. I consider the applicant worthy of an AFPE Pre-Doctoral Fellowship.
2. Tuition and Fees for this student ____ will ____ will not be waived.
3. As of today, this applicant's cumulative GPA is: _____
4. This applicant is enrolled full-time in a graduate program in pharmaceutical science administered by, or officially affiliated with, this school or college of pharmacy.

By signing below, I agree to the above terms and certify that all information contained on this application is accurate to the best of my knowledge.

Signature of Student Applicant

Print Name

Date

Signature of Dean of School/University
(*electronic signature permitted for dean*)

Print Name and Title

Date

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