SUNY DOWNSTATE Medical Center

Downstate School of Graduate Studies Summer Research Program June 1 to July 31, 2020

Please TYPE or print all information in BLACK INK.

Name: _____
Last First Middle

Date of Birth: _____ Place of Birth: _____ Gender: _____

Current Address: _____
Street City

_____ Telephone: _____
State Zip Code Area Code Number

Permanent Address: _____
Street City

_____ Telephone: _____
State Zip Code Area Code Number

Email: _____

Name of Applicant's: ☐ Parent ☐ Spouse ☐ Closest Relative :_____

Address: _____
Street City

_____ Telephone: _____
State Zip Code Area Code Number

Current College/University: _____

Faculty Advisor: _____

Faculty Advisor email: _____ Telephone: _____
Area Code Number

Briefly describe the research area you would be interested in for the summer program and what you hope to accomplish. Please attach a separate page if necessary.

Describe, in detail, any prior research experience you may have had.

With which faculty members would you be most interested in working, please elaborate.