

Dr. Barnett A. Slepian Memorial Fund Clinical Training Grant Application

Applications are accepted on an ongoing basis. All information provided in this application will be used by the Slepian Committee of the Pro-Choice Network of Western New York in the Application Review process. Your responses will be kept confidential. If you are selected to receive the Slepian Award, the Slepian Committee will contact you to request your permission to release specific information to the media. Releasing information to the media is voluntary and will not be a determining factor in the selection process for this award.

I. Applicant Information – to be completed by all applicants

1. Name _____

2. Citizenship _____

3. Medical School _____ Yr. in school _____ Graduation Date _____

4. Current Mailing Address: Valid Until _____

Street _____ Apartment Number _____

City _____ State _____ Zip Code _____

Telephone Numbers: Home _____
(include area codes)

Work _____

Cell _____

5. Permanent Mailing Address:

Street _____ Apartment Number _____

City _____ State _____ Zip Code _____

6. E-Mail Address _____

7. Name of Abortion Training Facility _____

Facility Address/Phone _____

II. Professional Information – to be completed by MDs only

1. License # _____ State _____ Exp. Date _____

2. Hospital Affiliation _____

3. Specialty _____

4. If the answer to any of the following questions is "yes," please give details on a separate sheet.

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? Yes No

Have you ever been refused membership on a hospital medical staff? Yes No

Has your request for any specific clinical privilege ever been denied or granted with stated limitations? Yes No

Have your privileges at any hospital ever been suspended, revoked or not renewed? Yes No

Has your narcotics registration ever been suspended or revoked? Yes No

Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? Yes No

III. Submissions – to be completed by all applicants

On a separate sheet, please answer the following questions and attach to this application form.

1. Please state and explain your position on including abortion as a part of reproductive health care for women.
2. As a recipient of this award, how much money are you requesting and how would you plan to utilize the grant? (i.e., for recent past or future training fees, housing, travel, other related expenses, etc.) Have you applied for other grants to support your abortion training? If yes, please specify.
3. How do you plan to utilize your abortion training?

IV. References – to be completed by all applicants

If necessary for the selection process, would you be willing to supply the Slepian Committee with two professional or academic references?

Yes No

V. Signature – to be completed by all applicants

I verify that all of the information provided in this application and accompanying materials is true and accurate.

Signature _____ Date _____

Please return this application to:

The Slepian Committee
Pro-Choice Network of WNY, Inc.
P.O. Box 461
Buffalo, NY 14209