DELTA DENTAL FOUNDATION

An affiliate of Delta Dental of Michigan, Ohio, and Indiana

Dental Master's Thesis Award Program Application

Contribution Request

APPLICANT:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

School, department and program: _____

Project title: _____

Email: _____ Phone: _____

Total cost of program: $_____ Amount requested: $_____

Expected graduation date: _____

THESIS ADVISOR:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____

REQUIRED ATTACHMENTS:

- Copy of full proposal (maximum three pages)
- Budget requirements/requests: Outline the budget requirements for the program. Make sure to provide as much detail as possible by separating out the line items appropriately.
- Letter of faculty endorsement from thesis advisor
- Copy of human subjects review committee approval
- Updates of human subjects approval and any protocol revisions must be submitted to the Delta Dental Foundation

Please complete and send this form and other materials to ddf@deltadentalmi.com or fax to 517-347-5320.

QUESTIONS?

Contact us at:

Delta Dental Foundation
PO Box 293
Okemos, MI 48805-0293
Phone: 517-347-5333
ddf@deltadentalmi.com