Complete, print and submit.

MAYO CLINIC

Master's Degree or Certificate Program Application

Center for Clinical and Translational Science (CCaTS)

Application packets that are incomplete will be returned to the applicant without review by the CCaTS Postdoctoral Programs Executive Committee. This application must be typed and demonstrate **proficiency in written English**. All the fields are required unless specified as optional.

A completed application packet must include:

1. **A completed application form.** (Must include all signatures on page 4.)
2. **A completed Initial Mentoring Agreement.**
   A. **For Master's Scholars only:** Your mentor must have or meet the criteria for Master or Full Level Faculty Privileges, including a minimum of an Associate Professor appointment, have demonstrated NIH or R01 funding (or the equivalent) and have had successful previous experience mentoring CCaTS scholars.
3. **Your current curriculum vitae, including bibliography.**
4. **A copy of USMLE and/or ECFMG scores (if available).**
5. **Research Fellows and Visiting Scientists – Please provide a transcript of your Medical School credits (copy acceptable).**
6. **Three letters of recommendation addressed to Dr. Prasad Iyer, Director, CCaTS Postdoctoral Programs, to include the following information:**

   Note: All letters must be submitted by the applicant as a part of full application packet.

   A. **Research Mentor** – Include a copy of your biosketch with mentor training record **or** CV and bibliography, as well as a letter of recommendation which must specifically address **each of the following**:
      1) The candidate's potential for success with respect to:
         a) Career goals
         b) Academic and/or research qualifications
      2) Your qualifications, including the following:
         a) Appointment type
         b) Academic rank
         c) Clinical research mentoring experience
         d) Publications in clinical research
      3) Your support for the candidate with respect to:
         a) How often you will meet with your candidate
         b) Resources you will provide, such as space, supplies, research support
      4) Confirmation that the candidate's work will represent a significant intellectual contribution toward the design,conduct, and analysis of the research and that the candidate will be first author on the manuscript/thesis resulting from it.
   B. **Program Director or Department/Division Chair** – Letter of recommendation must address the following:
      1) The candidate's motivation and likelihood to become an independent clinical researcher.
      2) Your support to provide the candidate with protected time for the course work and the research.
      3) Your support to pay the nonrefundable program fee.
   C. **Faculty member** – Letter of recommendation; or person acquainted with the candidate's personal, academic or professional qualifications.

Application packet deadlines:	**February 1, May 1, August 1, November 1**
Program fees:	$6,000 for Certificate Program; $12,000 for Master's Degree
Submit questions and application packets to:	CCaTS Education Programs: CCATSEDUCPROG@mayo.edu

Application begins on next page.

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Reset Form

Carefully read the instructions provided. This application form must be completed online and submitted, along with required supporting documentation, to the email address provided on the instruction page.

Select the program you are applying to: ☐ Certificate ☐ Master's	
Date of Application	PersonID

Personal Information

Applicant Name *(First, Middle, Last)*			Degree	ORCID
Street Address				
City	State or Province	ZIP or Postal Code	Country	
Work Email Address	Non-Mayo Email Address		Phone	
Permanent Address *(person through whom you can always be contacted)*				
City	State or Province	ZIP or Postal Code	Country	

Current Mayo Appointment

Department/Division	Appointment Begin Date	Appointment End Date

Appointment Type

☐ Medical Student ☐ Clinical Fellow ☐ Research Associate ☐ SAC
☐ Resident ☐ Research Fellow ☐ AC ☐ CONS

Are you currently on a training grant? Yes ☐ No ☐ If yes, specify with details:

☐ T32 _____ ☐ Population Health _____
☐ K award (KL2, Calebresi, etc) _____ ☐ Kern _____
☐ Mayo internal career development award _____ ☐ Mayo Foundation _____
☐ External career development award _____ ☐ BIRCWH _____
☐ CITP _____ ☐ Other _____

Education

Dates *(mm-yyyy)* From To	**College/University**		Degree	Major
	Street Address			
	City	State or Province	ZIP or Postal Code	Country
Dates *(mm-yyyy)* From To	**Medical/Dental School**			
	Street Address			
	City	State or Province	ZIP or Postal Code	Country

Application continues on next page.

Reset Form

Education (continued)

Dates *(mm-yyyy)* From To	**Residency Institution**		Specialty	
	Street Address			
	City	State or Province	ZIP or Postal Code	Country
Dates *(mm-yyyy)* From To	**Fellowship Institution**		Specialty	
	Street Address			
	City	State or Province	ZIP or Postal Code	Country

Training or Work Experience

List training or experience relevant to this program. Give nature of experience (practice, research, training, etc) and location. Include military service, if applicable. Attach additional pages if necessary.

Dates *(mm-yyyy)* From To	Description and Location
Dates *(mm-yyyy)* From To	Description and Location

Publications and Presentations

	Total ***(number)***	**First Author** ***(number)***
Peer reviewed articles (accepted or published)		
National presentations		

Career Plan (attach additional pages if necessary)

Describe the accomplishments you would like to achieve in the next 10 years.

Describe the percentage of effort you hope to devote to clinical research in your future practice.

Application continues on next page.

Reset Form

Career Plan (continued)

Describe your steps to achieve these goals.

Research Goals (attach additional pages if necessary)

Summarize your area of research interest.

Describe the research question you would be pursuing during the course of this program.

What methods, data and/or activities will you utilize to answer this question?

Describe the reasons you chose this mentor.

Application continues on next page.

Reset Form

Proposed Program Timeline

Program Milestones	Proposed Completion Date *(mm-yyyy)*	Specific amount of protected time you have to accomplish these milestones through program completion (ie, 80% for 12 months)
Proposal Submitted to IRB and Department Research Committee		
Data Collection Completed		Frequency/duration of mentor meetings (once/week for one hour recommended)
Manuscript/Thesis Written		
Course Work Completed		
Projected Program Completion Date		

Letters of Recommendation (three letters are required)

List below the name and department/division of your primary research mentor, division or department chair and a faculty member who will write recommendation letters.

Primary Research Mentor	Program Director or Department/Division Chair	Faculty Member
Department/Division	Department/Division	Department/Division

Mentor Certification

I have reviewed this application in detail and have provided direct feedback to the applicant regarding its contents.

Mentor Signature	Date *(mm-dd-yyyy)*
Signature Required	Date Required

Equal Opportunity/Affirmative Action (optional section)

The Mayo Clinic College of Medicine and Science is committed to a policy of equal opportunity and affirmative action in the appointment process. We request that you describe yourself by checking the appropriate boxes below.

Sex
☐ Female ☐ Male

Citizenship (check one)
☐ U.S. Citizen or U.S. Noncitizen National
☐ Permanent Resident of the U.S. (attach notarized copy of your Green Card)

Race/Ethnicity: Are you Hispanic or Latino?
☐ Yes ☐ No ☐ Intentionally withheld

Are you from a disadvantaged background?
☐ Yes ☐ No ☐ Do not wish to provide

Racial Background
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ More than one race
☐ Intentionally Withheld

Disability: A physical or mental impairment that substantially limits one or more major life activities. Do you have a disability?
☐ Yes ☐ No ☐ Do not wish to provide

If yes, which of the following describes your disability? (Check all that apply.)
☐ Hearing ☐ Visual ☐ Mobility/orthopedic impairment ☐ Other _____

Applicant Certification

I certify all the information I have provided is complete and accurate.

Applicant Signature	Date *(mm-dd-yyyy)*
Signature Required	Date Required

Program Fee Payment Agreement (to be completed by Department/Division Chair and Administrator)

I understand that if this applicant is accepted into the CCaTS Training Program, a program fee of $6,000 (Certificate) or $12,000 (Master's) will be charged on the date of acceptance and is non-refundable. The fee should be charged to the PAU/Activity number at right.

PAU Number

Activity Number

Administrator Name	Signature	Date *(mm-dd-yyyy)*
	Signature Required	Date Required
Department/Division Chair Name	Signature	Date *(mm-dd-yyyy)*
	Signature Required	Date Required

Print