
Title of Proposal: _____

Proposing Student: _____

Student Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Amount Requested: _____ Payable to: _____

Address to Send Check: _____

City: _____ State: _____ Zip: _____

University or College & Department in which Student is Enrolled:

As a faculty supervisor for the student named on this form, I am fully aware of the student's proposed research and will provide necessary guidance to the student.

Name of Faculty Member Faculty Member's Signature

Faculty Member Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Other Information:

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American School Health Association
Research Grant Application
PO Box 708
Kent, OH 44240

Incomplete applications will NOT be considered.