

**RESIDENT CLINICAL INNOVATION AWARD**

Completed cover form must be included with each award submittal. An incomplete form will delay review.

Applicant (First Name, Last Name, Credentials) Email:

Cell:

Residency Program:

|  |
| --- |
| Residency Complete Date: |
| **RESIDENT DIRECTOR ENDORSEMENT**Program Director Name: |
| Program Director Signature: |

PLEASE COMPLETE THIS FORM AND RETURN ALONG WITH THE FOLLOWING BY JULY 15.

 Completed summary of innovation worksheet

 Applicant’s curriculum vitae

**E-MAIL TO:**

sthornton@lugpa.org