



TRIOLOGICAL SOCIETY
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MEDICAL STUDENT TRAVEL AWARD VERIFICATION FORM

THIS IS AN EDITABLE PDF

1. Name _____
 First Middle Initial Last Degree
2. Name and Address of Medical School

3. Contact Person in Otolaryngology _____
4. Student's Business Phone _____ Student's Home or Cell Phone _____
5. Student's Email _____
6. Student's Home Address

7. I am submitting my abstract to:

Triological Society Combined Sections Meeting Triological Annual Meeting - COSM

MEDICAL STUDENT VERIFICATION BY INSTITUTIONAL REPRESENTATIVE

Name of medical student: _____

I verify this medical student is currently enrolled in good standing at the institution listed above and will be in the program through May 2022. I understand this student must be the first author and presenter of this paper at the meeting as well as the first author on any subsequent submissions to *The Laryngoscope* or *Laryngoscope Investigative Otolaryngology*.

Print Name of Otolaryngology Department Chair, Medical School Dean or medical school designee

Signature of individual authorized

Send Signed Verification Form to (choose one):
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