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 2023. 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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