

Supervisor Confirmation Form

Innovation Fellows

Innovation Fellows Program

Approval

First Name of Supervisor _____

Last Name of Supervisor _____

Work Email _____

Address of Supervisor _____

Phone Number for Supervisor _____

To be filled out by Supervisor or Department Head

Applicant is approved for full-time roles, part-time roles, or both?

Full-time roles

Part-time roles

Both

If part-time, please indicate the maximum allowable amount: _____

Selected Fellows' salary and fringe is reimbursed by Industry Host to Hospital and Fellows must remain Active employees (full or part-time) in the department throughout duration of Fellows Project. Has a plan been discussed for this?

Yes

No

Applicants funded through Government (NIH or other) training programs, NIH- or Industry-sponsored pre-clinical research or clinical research/trials have completed a Fellow's Program COI Checklist and meet or will meet the eligibility requirements by the start date of the Fellow's Project start date?

Yes

No

Was any discussion held relating to any post program plans to continue at BWH, MGH, or McLean?

Yes

No

Initial and Date: _____

*For any questions, please email innovationfellows@partners.org

(Signature of Applicant)

Name: _____

Date: _____

(Signature of Supervisor)

Name: _____

Date: _____

(Signature of Department Head, when applicable)

Name: _____

Date: _____