Disclosure of Graduate Student Stipend Support Form

For students enrolled in an MSc with thesis in BCH, CMM, MIC or NSC; or a PhD in BCH, CMM, MIC or NSC.

Return this form by email to grad.med@uOttawa.ca.									
Student Identification									
FIRST NAME	ME LAST NAME				STUDENT NUMBER				
Graduate program	Level:	□ MSc	□ PhD	Program:	□ ВСН	□СММ	□МІС	□ NSC	
All Faculty of Medicine studen supervisor or through an extern Office of the Vice-Provost, Gra to the minimum stipend provide	al scholarship duate and Pos	equivalent t tdoctoral St	to the minimum audies, provides	stipend. All students	are expected	d to seek an e	xternal scho	olarship. The	
Students who have not secure research grants or partially thro stipend (please see minimum sup to the guaranteed minimum.	ugh a Teachin tipend amount	g Assistant	(TA) position. If	a student receives a	an award that	is less than th	ne minimun	n guaranteed	
It is the supervisor's responsible in the case where a student is encounter financial difficulties of	on medical le	eave, the st	ipend payments	must continue for	a maximum o	of four weeks.			
Guaranteed stipend must cove program and fast-track to the F judged satisfactory in all previous writing the thesis; if not, any fur final approval. In the event of a case, the supervisor has the rigorous program of the supervisor factors.	PhD program wous progress retailed the resupport constitution of the result of the res	ithout writin eports, then an be negot progress in t	g a master's the support should tiated between the the research pro	esis will be supporte be provided for the ne student and the s	d for five yea duration of t supervisor and	rs. If the stude he research a d reported to t	ent's progre and approp the Program	ess has been riate time for Director for	
Minimum Guaranteed	Stipend fo	r the Fac	culty of Med	licine Graduate	e Student	S (EFFECTIVE	E FEBRUAF	RY 2024)	
■ MSc with thesis in BCH, CMM, N	IIC or NSC: Min	imum stipend	d of \$23,000/yea ı	■ PhD in BCH, CN	MM, MIC or NS	SC: Minimum s	tipend of \$2	5,000/year	
Supervisor's Commitm	nent								
By signing this form, you acknow Have read the studen Accept to follow and by Will take full responsi	t's application be aware of the	and intervie regulations	governing the I	aculty of Medicine		grams			
□ SCHOLARSHIP □ STIP	END SOUF	RCE:		AMOUNT PER YEAR:					
Signatures									
NAME OF SUPERVISOR				IGNATURE (SUPERVISOR)			DATE	(YYYY-MM-DD)	
NAME OF THE CO-SUPERVISOR (IF APPLICABLE)				IGNATURE (CO-SUPERVISOR)			DATE	(YYYY-MM-DD)	
Year Fall□ Spri	ng/Summer	□ Winte	er□						

IMPORTANT: For your financial support to be activated, you must contact the Department administrator to fill out the contract.

SIGNATURE (STUDENT)