

# Academic Fellowship Form

Please check one:  New  \*Change  Addition to  Early Termination

## People Data

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Social Security # (if new to RF) \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender:  Male  Female

Title:  Dr.  Mr.  Mrs.  Ms.  Miss  
 Nationality:  U.S. Citizen  Non-Citizen in U.S. on VISA  Non-Citizen Not in U.S.  Permanent Resident  
 \*Ethnic Origin (select all that apply):  
 American Indian or Alaskan Native  
 Asian  
 Black or African American  
 Hispanic or Latino  
 Native Hawaiian/Other Pacific Islander  
 White

Mail To:  Home  Office  
 \*Visa Type \_\_\_\_\_ **Check Delivery Drop** \_\_\_\_\_

\*Country \_\_\_\_\_ **Assignment Number** \_\_\_\_\_

I-9 Expiration Date \_\_\_\_\_ \*Please attach a copy of the passport, I-94, and I-20 or IAP66

## Special Information

Education Level \_\_\_\_\_ Other Special Information?  Yes  No

Degree Expected \_\_\_\_\_ If Yes, please specify:

Date Degree Expected \_\_\_\_\_

## Address

Primary U.S. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Country \_\_\_\_\_

Secondary Address \_\_\_\_\_  U.S.  Foreign

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Country \_\_\_\_\_ Email Address \_\_\_\_\_

## Health Insurance

Grant Pays \_\_\_\_\_

Fellow Pays \_\_\_\_\_

Individual \_\_\_\_\_

Individual + 1 \_\_\_\_\_

Individual + 2 \_\_\_\_\_

**\*\*\*Fellow must submit Health Insurance Form For more information, please contact Benefits at 632-6180**

## Assignment

Organization \_\_\_\_\_ Group: Fellow

## Salary

## Award Data

Award Amount \$ \_\_\_\_\_

Fellow Type:

Faculty

Award Begin Date \_\_\_\_\_

\*Postdoc

Grad

Award End Date \_\_\_\_\_

Undergrad

\* If this employee is a Postdoc, please attach a copy of their PhD.

\*\*If changing, enter award amount and dates

# Academic Fellowship Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ RFID \_\_\_\_\_

Current Labor Distribution							
Project	Task	Award	Organization	Expenditure Type	Start Date	End Date	%

New Labor Distribution							
Schedule Line Changes							
Project	Task	Award	Organization	Expenditure Type	Start Date	End Date	%

Fellow Health Insurance Labor Schedule							
Project	Task	Award	Organization	Expenditure Type	Start Date	End Date	%

**Declaration (required for initial award only)**

I acknowledge that no services are required of me in consideration of the stipend provided by this fellowship award. I understand that as a fellowship recipient engaged in study or research on a State University of New York campus I am subject to the Patent Waiver and Release Agreement and the University's academic policies applying to fellowship recipients.

*Patent Waiver and Release Agreement:*

I have read the [Patent and Inventions Policy](#) and the [Computer Software Policy](#) of the Research Foundation. I agree to abide by any additional terms and conditions relating to the above policies as required by any sponsor from whom I accept support through the Research Foundation.

In fulfillment of the above, I will promptly report to the Research Foundation or its designee such patentable inventions, discoveries, and computer software and software support materials as may arise out of work supported by the sponsor and will cooperate with the sponsor, the State University of New York, or the Research Foundation in the preparation and prosecution of any patent or copyright applications relating to such inventions, discoveries, and computer software and software support materials, and will execute all documents necessary to such applications.

Further, I hereby assign all patent rights and copyrights applicable to such inventions, discoveries, computer software and software support materials to the sponsoring agency, to the State University of New York, to the State University of New York's designee, or to the Research Foundation in those instances where the applicable sponsor policy or the State University of New York's Patents and Inventions Policy or Computer Software Policy places ownership of such in either the sponsor, the State University of New York, or the Research Foundation.

Fellowship Receipt Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Approvals**

This assignment is permissible under the terms stated by the above sponsor.

Project Director/Co-Director \_\_\_\_\_ Department Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Operations Manager:

Signature \_\_\_\_\_ Date \_\_\_\_\_

This fellowship assignment is consistent with SUNY academic policy and procedure.

SUNY Academic Officer:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional Campus Signatures as Required:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Input by \_\_\_\_\_ Date \_\_\_\_\_

Labor Distribution Input By \_\_\_\_\_ DA Required \_\_\_\_\_ DA Input \_\_\_\_\_