**2023 Shore Program Application**

**IMPORTANT DATES**  
**Application Opens:** Wednesday, January 4, 2023, 10:00 AM  
**Application Closes:** Wednesday, February 1, 2023, 5:00 PM  
**Endorsement Deadline:** Wednesday, February 8, 2023, 5:00 PM  
**Award Notifications:** May/June 2023  
    
[Request for Application (RFA) [.pdf]](https://fa.hms.harvard.edu/files/hmsofa/files/shore_program_application_rfa_-_single_stream_-_11.22.2022_-_final.pdf)  
[Frequently Asked Questions (FAQ) [.pdf]](https://fa.hms.harvard.edu/files/hmsofa/files/shore_program_application_faq_-_11.22.2022_-_final.pdf)  
[Application Checklist [.pdf]](https://fa.hms.harvard.edu/files/hmsofa/files/shore_program_application_document_submission_checklist_11.22.2022_-_final.pdf)  
[Shore Program Academic Promise Template [.doc]](https://fa.hms.harvard.edu/files/hmsofa/files/shore_program_academic_project_template_11.22.2022.docx)  
   
If you have any questions or concerns, contact [HMSOFA\_Programs@hms.harvard.edu](mailto:HMSOFA_Programs@hms.harvard.edu).  
    
**IMPORTANT: This application form cannot be saved prior to submission.** **Please prepare and save your responses elsewhere prior to completing this application to prevent data loss.  Your application will be considered incomplete until you submit all required materials. Incomplete applications will not be reviewed.**  
     
    
\* = Required Field

First Name \*

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Middle Name

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Last Name \*

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Degree(s) \*  
 *Please select all that apply.*

* MD, DMD or equivalent
* PhD or equivalent

Email Address \*   
*Email notifications regarding this application will be sent to this address.*

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Harvard ID Number \*  
 If you are unsure of your ID number located on your Harvard ID Card, please email [hmsofa\_programs@hms.harvard.edu](mailto:hmsofa_programs@hms.harvard.edu?subject=Request%20for%20Harvard%20ID)

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Phone Number \*  
*A number where we can reach you directly, e.g., cell phone.*

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Primary Job Location \*  
   
*Please indicate your primary physical work location.*

* Affiliate Institution
* HMS Quad Department
* Harvard School of Dental Medicine

Display This Question:

If Primary Job Location \* Please indicate your primary physical work location. = Affiliate Institution

Please specify your Affiliate Institution. \*

* Baker Center for Children and Families
* Beth Israel Deaconess Medical Center
* Boston Children's Hospital
* Brigham and Women's Hospital
* Cambridge Health Alliance
* Dana-Farber Cancer Institute
* Harvard Pilgrim Health Care Institute
* Hebrew SeniorLife
* Joslin Diabetes Center
* Massachusetts Eye & Ear
* Massachusetts General Hospital
* McLean Hospital
* Mount Auburn Hospital
* Spaulding Rehabilitation Hospital
* Veterans Affairs Boston Healthcare System

Display This Question:

If Primary Job Location \* Please indicate your primary physical work location. = HMS Quad Department

Please specify your HMS Quad Department. \*

* Biological Chemistry and Molecular Pharmacology (BCMP)
* Biomedical Informatics (DBMI)
* Cell Biology
* Genetics
* Global Health and Social Medicine (GHSM)
* Health Care Policy (HCP)
* Immunobiology
* Microbiology
* Neurobiology
* Stem Cell and Regenerative Biology
* Systems Biology

Display This Question:

If Primary Job Location \* Please indicate your primary physical work location. = Harvard School of Dental Medicine

Please specify your HSDM Department. \*

* Developmental Biology
* Oral Health Policy and Epidemiology
* Oral and Maxillofacial Surgery
* Oral Medicine, Infection, and Immunity
* Restorative Dentistry and Biomaterials Sciences

Display This Question:

If Primary Job Location \* Please indicate your primary physical work location. = Affiliate Institution

Please indicate your primary department affiliation. \*   
*If you are in the Department of Medicine at BCH, please choose "Pediatrics" instead".*

* Anaesthesia
* Dermatology
* Emergency Medicine
* Medicine
* Neurology
* Neurosurgery
* Obstetrics, Gynecology & Reproductive Biology
* Ophthalmology
* Orthopedic Surgery
* Otolaryngology Head and Neck Surgery
* Pathology
* Pediatrics
* Physical Medicine & Rehabilitation
* Population Medicine
* Psychiatry
* Radiation Oncology
* Radiology
* Surgery

Position/Rank \*  
 *Please select your academic appointment as of February 1, 2023.  Clinical and Research Fellows anticipating an academic appointment after this date are not eligible to apply.*

* Instructor
* Assistant Professor
* Appointed as Member of the Faculty anticipating evaluation for Assistant Professor

Status \*

* Part-time
* Full-time

My primary role is as a... \*   
*We understand that applicants may identify with more than one role, but ask that you select your primary role.*

* Clinician
* Educator
* Investigator

**Current Award Opportunities**  
   
 By submitting a completed and endorsed application, **ALL** applicants will be considered for the Harvard Medical School Faculty Development Award and Eleanor and Miles Shore Family Award (HMS/HSDM-wide).

I would like to apply for the following program-specific awards: \*  
 *Please select all award opportunities for which you are eligible and will apply through this single-stream application.  Please review the award descriptions outlined in the Request for Application.*

* HMS/HSDM-wide Award Only (all should check this box)
* Beth Israel Deaconess Medical Center Department of Anaesthesia John Hedley-Whyte Research Fellowship
* Beth Israel Deaconess Medical Center Department of Emergency Medicine Research Development Award
* Beth Israel Deaconess Medical Center Department of Medicine Fellowship
* Beth Israel Deaconess Medical Center Department of Gynecology and Obstetrics Fellowship
* Beth Israel Deaconess Medical Center Department of Surgery Fellowship
* Boston Children’s Hospital Department of Neurology Faculty Development Fellowship
* Boston Children’s Hospital Department of Neurosurgery Fellowship
* Brigham and Women's Hospital Department of Medicine Fellowship
* Brigham and Women's Hospital Department of Pathology Fellowship
* Brigham and Women's Hospital Department of Radiology
* Dana-Farber Cancer Institute Fellowship Award
* Harvard School of Dental Medicine Fellowship in honor of Aina M. Auskaps, DMD
* Massachusetts General Hospital Department of Anaesthesia Fellowship
* Massachusetts General Hospital Department of Dermatology Fellowship
* Massachusetts General Hospital Department of Emergency Medicine Fellowship
* Massachusetts General Hospital Department of Medicine Fellowship
* Massachusetts General Hospital Department of Pathology Faculty Award
* Massachusetts General Hospital Department of Pediatrics
* Massachusetts General Hospital Department of Radiology Faculty Award

How would the award impact your career development? \*  
*Do not include any reference to personal need; there will be relevant questions later in the application.  Response to this question should focus solely on your academic trajectory.*

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**PROJECT INFORMATION**

Project Title \*

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Project Layperson Summary (80 to 100 words): \*   
*If selected, this description will be used in the program booklet of the annual celebration hosted in the fall.*

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What grants have you received as a PI? \*  
 *Please check all that apply.*

* None
* K-level
* R-level
* Foundation
* Industry
* Intramural
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a current startup funding package as part of your recruitment? \*

* No
* Yes

If yes, how much is available to you this year?

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Please list any current grant support and describe how this relates to the award that you are requesting.  How does it differ?  How does it overlap?  Please note total direct costs for each source of support.

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Please note any pending grant applications related to this proposal and the status of those applications.

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Does your proposed project require IRB (Institutional Review Board) application? \*

* Yes
* No

If yes, please select the status of IRB (Institutional Review Board) application required for your proposed project.

* Approved (IRB)
* Submitted and pending approval (IRB)
* Not yet submitted (IRB)

Approval or Submission Date:  
 *Please enter in the approval or submission date.*

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If no yet submitted, please describe your plans for submission:

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Does your proposed project require IACUC (Institutional Animal Care and Use Committee) application? \*

* Yes
* No

If yes, please select the status of IACUC (Institutional Animal Care and Use Committee) application required for your proposed project.

* Approved (IACUC)
* Submitted and pending approval (IACUC)
* Not yet submitted (IACUC)

Approval or Submission Date:  
 *Please enter in the approval or submission date.*

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If no yet submitted, please describe your plans for submission:

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**SUPPORTING DOCUMENTS**   
*The following documents* ***must be*** *submitted as a* ***single****(1) PDF file in the order listed below.*  Please use the following filename convention, e.g. **smith, john\_Shore2023**.

**Application: Single PDF Document Upload: \***    
[*Click here for word document template to be converted into a Single PDF Document.*](https://fa.hms.harvard.edu/files/hmsofa/files/shore_program_academic_project_template_11.22.2022.docx)

Project description (1-2 pages exclusive of references)

Budget Proposal (up to 1 page)

Sample Budget for Research Proposal (for all award denominations)

Copy of IRB approval or submission confirmation, if currently under review

Copy of IACUC approval or submission confirmation, if currently under review

Curriculum Vitae (no biosketch). Applicants whose CV does not follow the Faculty of Medicine guidelines will not be accepted. Information about the CV guidelines may be found at <https://fa.hms.harvard.edu/faculty-medicine-cv-guidelines>

**PERSONAL NEED**   
    
These questions are designed to understand your personal need for support.  **The information is kept confidential and will not be shared with your department.**

**Household Composition**

Children: \*  
 *You may count any current pregnancy or expected adoption as one child.*

* None
* 1 child
* 2 children
* 3 or more children

Ages of children:   
*Please enter the ages of your children.  Numbers only, e.g., 2, 5, 10*

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Parenting: \*  
 *Sole caregiver is equivalent to single parenting.  Please estimate # of hours/week that you devote to parenting.*

* None or N/A
* Shared caregiver < 20 hours/week
* Shared caregiver > 20 hours/week
* Sole caregiver < 40 hours/week
* Sole caregiver > 40 hours/week

Total childcare costs (e.g. daycare, nanny, afterschool programs, etc.): \*  
 *Please select the estimated cost per week on childcare.*

* None or N/A
* < $500 /per week
* $500-1000 /per week
* $1000-1500 /per week
* > $1500 /per week

Childrearing: \*  
 *Please select the most accurate description of your supports in raising children.*

* N/A
* Stay at home spouse/nanny
* Self/Spouse flexibility
* Other family/friends
* Support not available

**Financial Stressors**

Total household student loans: \*

* None
* < $50,000
* $50k-100k
* $100k-150k
* > $150k

Housing costs percentage of total household (net income): \*

* < 50% total household income
* > 50% total household income
* > 75% total household income

Please indicate what percentage of your net income these financial commitments in total represent. \*

* 0-20%
* 20-40%
* 40-60%
* 60-80%
* 80-100%

Does anyone in your household do clinical moonlighting work? \*

* Yes
* No

**Daily Commute**

Length of commute to work. \*

* < 30 minutes one way
* > 30 minutes one way
* > 1 hour one way

**Dependent Family Members (outside of partner/children)**

Location of dependents. \*

* None
* Live-in
* In New England
* Outside of New England
* International

Time caring for other dependents. \*

* None
* < 5 hours/week
* 5-10 hours/week
* > 10 hours/week

Financial contributions for other dependents. \*

* None
* < $500 /per week
* $500-1000 /per week
* $1000-1500 /per week
* > $1500 /per week

**Health Stressors (in the past 1 year)**

Personal health \*   
*How often does personal health problems impact your work life?*

* None
* Less than weekly impact
* Illness with weekly impact
* Illness with daily impact

Condition/Diagnosis   
*Please list the personal condition/diagnosis that is impacting* ***your*** function.

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Partners health \*   
*How often does health-related issues of your partner impact your work life?*

* None or N/A
* Less than weekly impact
* Illness with weekly impact
* Illness with daily impact

Condition/Diagnosis    
*Please list your partner's condition/diagnosis.*

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Child's health \*   
*How often does health-related issues of your child impact your work life?*

* None or N/A
* Less than weekly impact
* Illness with weekly impact
* Illness with daily impact

Condition/Diagnosis   
*Please list your child's condition/diagnosis.*

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Parent's health \*   
*How often does health-related issues of your parent impact your work life?*

* None or N/A
* Less than weekly impact
* Illness with weekly impact
* Illness with daily impact

Condition/Diagnosis   
*Please list your parent's condition/diagnosis.*

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**Support Systems**

Work (e.g. flexibility, time-off, etc.) \*

* Very flexible
* Somewhat flexible
* Not flexible

**Impact of Stressors**

Please rate your financial stressors \*   
*Please rate financial stressors from 1 to 5 with 5 being the most stressful.*

* 1
* 2
* 3
* 4
* 5

Please rate your health stressors \*   
*Please rate health stressors from 1 to 5 with 5 being the most stressful.*

* 1
* 2
* 3
* 4
* 5

Please rate your overall stressors \*   
*Please rate your combined stressors from 1 to 5 with 5 being the most stressful.*

* 1
* 2
* 3
* 4
* 5

Describe how receiving this funding would assist you in work/life balance. \*

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Please give any additional information you would like considered in this review of your personal need. \*   
*If not applicable, please enter "N/A".*

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In order to be considered complete, this application requires endorsements from your Primary Project Mentor.  We recognize that some projects might have more than one mentor, we ask that you include your primary only.  **This online evaluation is required by Wednesday, February 9, 2023, 5:00 PM.**

Primary Project Mentor Full Name \*   
*Enter only one (1) name, First and Last Name.*

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Primary Project Mentor Email \*  
 *Enter only one (1) email address to trigger automated email.*

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To apply you must agree to the program requirements. \*

* By checking this box, I certify that, I understand the following: By clicking "submit" my application has been submitted, but incomplete, pending endorsements My endorser will be informed via email that an endorsement is requested by February 9, 2023, 5:00 PM My endorser will not have access to my full application submission The review process does not begin until after the application deadline We also ask that you take a moment to add HMSOFA\_Programs@hms.harvard.edu to your email account’s safe list to ensure that you successfully receive future correspondence.