



FULL-TIME EDUCATOR DEVELOPMENT GRANT

DEADLINE FOR APPLICATIONS

Rolling

THE GRANT

The Foundation for Endodontics will provide AAE Educator Members reimbursement *up to* \$1,500 to attend any of the meetings listed below. The goal of a single funding opportunity is to provide greater flexibility for applicants and to ensure that educators are getting the professional development opportunities that meet their individual needs. Applicants should complete the registration process for the meeting/s they wish to attend and pay registration in full. Reimbursement will occur only after proof of registration, travel and lodging expenses are submitted. Please submit all applicable meeting receipts at one time, for the full reimbursable amount.

Electronic submission required, preferred receipt format is one PDF document.

ELIGIBILITY

Full-time educators who meet the criteria listed below are eligible for reimbursement.

1. The applicant must be a full-time educator as defined by their respective institution. Applicants must be involved in pre-doctoral and/or postdoctoral teaching (graduate endodontic programs/GPR programs/AEGD programs).
2. Applicants may be general dentists, researchers or endodontists, but must be members of the AAE. Non-members must file a membership application prior to being eligible.
3. Applicants must be teaching in accredited U.S. or Canadian dental schools or medical schools/centers.

Along with the completed form, the applicant must provide a letter from the institution's dean or administrative head confirming:

1. The school's criteria for classification as a full-time faculty member.
2. The individual's status as a full-time faculty member.



FULL-TIME EDUCATOR DEVELOPMENT GRANT

Name _____

Academic Title _____

Institution _____

Number of Hours/Days Spent Teaching _____

Mailing Address _____

City/State/Zip/Country _____

Phone _____ Fax _____

Email _____

Social Security Number (must have to issue check) _____

Reimbursement may be requested for any of the following meetings, total not to exceed \$1,500. Reimbursement will only be issued if receipts for registration and other expenses are submitted, along with the completed grant expense form.

- | | |
|--|-----------------------------|
| <input type="checkbox"/> AAE annual meeting | Reimbursement requested: \$ |
| <input type="checkbox"/> AAE Insight Track | Reimbursement requested: \$ |
| <input type="checkbox"/> College of Diplomates Board Review Course | Reimbursement requested: \$ |
| <input type="checkbox"/> College of Diplomates Summer Conference | Reimbursement requested: \$ |
| <input type="checkbox"/> Other AAE meeting (ex: Joint Symposium, Winter Meeting) | Reimbursement requested: \$ |
| <input type="checkbox"/> ADEA Annual Meeting | Reimbursement requested: \$ |
| <input type="checkbox"/> ADEA Fall Meeting | Reimbursement requested: \$ |
| <input type="checkbox"/> ADEA Institute for Teaching and Learning | Reimbursement requested: \$ |
| <input type="checkbox"/> American Association for Dental Research Meeting | Reimbursement requested: \$ |
| <input type="checkbox"/> International Association for Dental Research Meeting | Reimbursement requested: \$ |
| <input type="checkbox"/> International Association for Dental Traumatology Meeting | Reimbursement requested: \$ |

The institution does not provide funding to attend the meetings that will be reimbursed by the Foundation for Endodontics.

Signature of department administrator

MEMBERSHIP

☐ I am an AAE member. Member Number: _____

☐ I have applied for AAE membership Date submitted application: _____

Return this form with the necessary attachment to:
Development Coordinator
211 E. Chicago Ave., Suite 1100, Chicago, IL 60611-2691
Fax: 866/451-9020 (North America) or 312/266-7255
(International) Email: ncarpenter@aae.org