



**TRIOLOGICAL SOCIETY**  
**13930 Gold Circle, Suite 103 • Omaha, NE 68144**  
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**MEDICAL STUDENT TRAVEL AWARD VERIFICATION FORM**

**THIS IS AN EDITABLE PDF**

1. Name \_\_\_\_\_  
First Middle Initial Last Degree
2. Name and Address of Medical School  
\_\_\_\_\_  
\_\_\_\_\_
3. Contact Person in Otolaryngology \_\_\_\_\_
4. Student's Business Phone \_\_\_\_\_ Student's Home or Cell Phone \_\_\_\_\_
5. Student's Email \_\_\_\_\_
6. Student's Home Address  
\_\_\_\_\_  
\_\_\_\_\_
7. I am submitting my abstract to:  
Triological Society Combined Sections Meeting                      Triological Annual Meeting - COSM

**MEDICAL STUDENT VERIFICATION BY INSTITUTIONAL REPRESENTATIVE**

Name of medical student: \_\_\_\_\_

I verify this medical student is currently enrolled in good standing at the institution listed above and will be in the program through May 2019. I understand this student must be the first author and presenter of this paper at the meeting as well as the first author on any subsequent submissions to *The Laryngoscope* or *Laryngoscope Investigative Otolaryngology*.

\_\_\_\_\_  
*Print Name of Otolaryngology Department Chair, Medical School Dean or medical school designee*

\_\_\_\_\_  
*Signature of individual authorized*

Send Signed Verification Form to (choose one):  
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