**Department of Health and Human Services**
**Public Health Services**

# Statement of Appointment

*(Please Type)*

***Follow attached instructions carefully.*** Submit this form to the PHS awarding component at the time the individual is appointed, is reappointed, or the reported appointment is amended. For a new postdoctoral trainees under a Kirschstein-NRSA award, a signed and dated payback agreement **must** accompany this form.

1. PHS GRANT NUMBER 5 T32 HS 66-24

| Type | Activity | ID Serial No. |
|---|---|---|
| 5 | T32 | 66 |

2. APPOINTEE'S NAME *(Last, first, initial)*

Shen, Nicole, T

3. SEX ☒ Completed

☐ M ☐ F

☐ Do Not Wish to Provide

4. TYPE OF ACTION *(Mark X for only one type)*

☒ NEW appointment (NOT previously supported by this grant)
☐ REAPPOINTMENT (Previously supported by this grant)
☐ AMENDMENT of items checked: ☐ 15 ☐ 20

5. PRIOR NRSA SUPPORT *(Individual or institutional)*

☒ NO ☐ YES (If "Yes", see instructions)

6. SOCIAL SECURITY NO.

XXX-XX-XXXX

7. BIRTHDATE *(Month, day, year)*

MM/DD/YYYY

8. CITIZENSHIP *(See instructions)*

☒ U.S. Citizen or Noncitizen National

Non-U.S. Citizen
☐ With a Permanent U.S. Resident Visa ("Green Card")
☐ With a Temporary U.S. Visa
☐ Not Residing in the U.S.

If not a U.S. citizen, of which country are you a citizen? UNITED STATES

9. PERMANENT MAILING ADDRESS

1755 York Avenue Apt 5N
New York, NY 10128
E-mail shennt@gmail.com

10. Are you Hispanic (or Latino)? *Mark(X)* ☒ Completed ☐ YES ☐ NO ☐ Intentionally Withheld

11. What's your racial background? *Mark (X) one or more*

☒ Completed
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Asian
☐ Black or African American
☐ White
☐ Intentionally Withheld

12. Do you have a disability? ☒ Completed

☐ YES ☐ NO ☐ Do not wish to provide

If yes, which of the following categories describe your disability(ies):

☐ Hearing ☐ Mobility/Orthopedic Impairment
☐ Visual ☐ Other

13. Are you from a disadvantaged background? (Applies to high school and undergraduate appointees only) ☐ Completed

☒ Not Applicable ☐ YES ☐ NO ☐ Do Not Wish to Provide

14. FIELD OF RESEARCH TRAINING OR CAREER DEVELOPMENT *(for this appointment)*

Enter a 3 digit code from instructions: 290

15. PERIOD OF APPOINTMENT *(Month, day, year)*

From: 07/01/2017 To: 06/30/2018

16. EDUCATION – AFTER HIGH SCHOOL *(Indicate all academic and professional education. For foreign degrees, give U.S. equivalent.)*

| (a) Name of Institution and Location (List most recent first) | (b) Degree(s) Received | | (c) Major Field | (d)Minor Field |
|---|---|---|---|---|
| | Degree | Mo./Yr. | | |
| University of Missouri-Columbia | MD | 05/2013 | | |
| Vanderbilt University | BA | 05/2009 | Chemistry | Chinese and English |
| | | | | |

| | | |
|---|---|---|
| 17. NAME OF SPECIALTY BOARDS *(if applicable)* | | |
| 18. DEGREE(S) SOUGHT ☐ YES ☒ NO | If yes, indicate type of degree(s) | |
| Are you in a dual degree program (e.g., M.D./Ph.D.)? ☐ YES ☒ NO | | |
| 19. EXPECTED COMPLETION DATE FOR DEGREE(S) *(mm/yyyy, if applicable)* | | |

| 20. SUPPORT FOR PERIOD OF APPOINTMENT | | |
|---|---|---|
| Type | Total of this Grant *(Omit cents.)* | |
| Stipend /Salary / Other Compensation | $ | 52140 |
| TOTAL | $ | 52140 |

21. STATEMENT OF NONDELINQUENCY ON U.S. FEDERAL DEBT. Is the appointee delinquent on the repayment of any U.S. Federal debt(s)?

☒ NO ☐ YES *(If "Yes," please explain below.)*

| | | |
|---|---|---|
| 22. CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true and complete to the best of my knowledge and that I will comply with all applicable Public Health Service terms and conditions governing my appointment. I am aware that any false, fictitious or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. | (a) SIGNATURE OF APPOINTEE<br><br>Electronically certified via eRA xTrain system by Trainee | (b) DATE<br><br>09/12/2017 |
| 23. This individual is qualified for this program and is eligible to receive financial support for the period specified above. A copy of this appointment form will be given to the individual. | (a) SIGNATURE OF PROGRAM DIRECTOR<br><br>Electronically certified via eRA xTrain system by PI | (b) DATE<br><br>09/12/2017 |
| (c) NAME OF PROGRAM DIRECTOR | CHARLSON, MARY E | |
| (d) INSTITUTION'S NAME, ADDRESS, AND PHONE NO. (Street, city, state, zip code) | WEILL MEDICAL COLL OF CORNELL UNIV<br><br>WEILL MEDICAL COLLEGE OF CORNELL UNIV<br>1300 YORK AVENUE, BOX 89<br>NEW YORK, NY 100654805<br><br>Phone : 646-962-8290 | |

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| Type | Activity | ID Serial No. |
|---|---|---|
| 3 | T32 | 66 |

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Shen, Nicole, T

3. SEX ☒ Completed

☐ M ☐ F

☐ Do Not Wish to Provide

4. TYPE OF ACTION *(Mark X for only one type)*

☐ NEW appointment (NOT previously supported by this grant)
☒ REAPPOINTMENT (Previously supported by this grant)
☐ AMENDMENT of items checked: ☐ 15 ☐ 20

5. PRIOR NRSA SUPPORT *(Individual or institutional)*

☐ NO ☒ YES (If "Yes", see instructions)

*See 'PRIOR NRSA SUPPORT' section on the Page 1 continued*

6. SOCIAL SECURITY NO.

XXX-XX-XXXX

7. BIRTHDATE *(Month, day, year)*

MM/DD/YYYY

8. CITIZENSHIP *(See instructions)*

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|---|---|---|---|---|
| | Degree | Mo./Yr. | | |
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| Vanderbilt University | BA | 05/2009 | Chemistry | Chinese and English |
| | | | | |

## PRIOR NRSA SUPPORT

| Period of Support | Grant No. |
| --- | --- |
| 07/01/2017 - 06/30/2018 | 5 T32 HS 66-24 |