



CREST Program

Clinical
Research
Enhancement *through*
Supplemental
Training

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CREST Website :
<http://crest.ucsd.edu>

Student Name: _____

Agreement of Primary Supervisor (e.g. Program Director, Research Advisor, Division Chief, Clinical Supervisor)

I support the applicant's participation in the CREST program; CREST core courses are offered Wednesdays/Thursdays from 4-6 PM and additional modules are offered once a week on Mondays/Tuesdays from 4-7pm.

I certify that participation in the CREST program on Monday/
Tuesday/ Wednesdays/Thursdays will not conflict with her/his research,
clinical or other duties.

I will provide protected time for her/him to participate in CREST activities. I
understand that there is a fee associated with the program that will be paid by
the scholar---- / department---

Signature

Name (printed)

Please return the signed agreement by mail or fax to:

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