



**SCLERODERMA FOUNDATION
RESEARCH GRANT AWARD
REQUEST FOR CARRY OVER OF FUNDS**

Carry over requests must be submitted if carry over exceeds 5% of annual award amount.

Awardee Name: _____

Institution: _____

Award Type: New _____ Established _____

Carryover from Year _____ to Year _____
(i.e. 1 to 2)

Dates of Carryover Request: _____
(i.e. 1.1.08-6.30.08)

Carryover Amount: \$ _____
(May not exceed 20% of annual grant award)

Justification: (use additional pages as necessary)

❖ Reason Funds Remain:

❖ How funds will be used in current year:

Please return form via e-mail, fax or mail to:

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978-463-5843
978-463-5809 Fax Email: tsperry@scleroderma.org