SCLERODERMA FOUNDATION RESEARCH GRANT AWARD
REQUEST FOR NO-COST EXTENSION

Name of Awardee: __________________________
Institution: ________________________________
Award Type: ________________________________
Length of Extension:
(Note: No-cost extensions cannot be granted for longer than six months.)
Carryover Amount if applicable: $__________
Justification: (use additional pages as necessary)
  • Reason For Extension Request:

If there is a carry-over of funds, a carry-over form must be submitted in addition to extension request.

Return to: Scleroderma Foundation
300 Rosewood Drive, Suite 105
Danvers, MA 01923
978-463-5843
978-777-1313 fax
research@scleroderma.org

8/09