Form Approved Through 10/31/2018
OMB No. 0925-0002

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 trainee under a Kirschstein-NRSA award, a signed and dated payback agreement **must** accompany this form.

1. PHS GRANT NUMBER
Type: 4 | Activity: T32 | ID Serial No.: GM103702-04

2. APPOINTEE'S NAME *(Last, first, initial)*: Trivedi, Hirsh, D

3. SEX
☒ M ☐ F
☐ Do Not Wish to Provide

4. TYPE OF ACTION *(Check 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- 0833

7. BIRTHDATE *(Month, day, year)*
06/11/1986

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

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

9. PERMANENT MAILING ADDRESS
228 Newbury St., Apt. 31
Boston, MA 02116

E-mail: htrived1@bidmc.harvard.edu

10. Are you Hispanic (or Latino)? ☐ YES ☒ NO ☐ Do Not Wish to Provide

11. What is your racial background? *Check one or more*
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☒ Asian
☐ Black or African American
☐ White
☐ Do Not Wish to Provide

12. Do you have a disability?
☐ 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)*
☒ 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: 2 9 0

15. PERIOD OF APPOINTMENT *(Month, day, year)*
From: 06/30/2017 To: 06/29/2018

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.		
BIDMC (Boston, MA)	Clinical Fellow	06/2017	Hepatology	
St. Elizabeth's Medical Center (Boston, MA)	Resident Physician	06/2016	Internal Medicine	
Sri Ramachandra Medical College & Research Institute (Chennai, India)	M.B.B.S.	08/2012	Medicine	

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 for this Grant *(Omit cents)*
Stipend / Salary / Other Compensation	$ 53,160
TOTAL	$ 53,160

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	(b) DATE
		5/28/17
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	(b) DATE

(c) NAME OF PROGRAM DIRECTOR Wolfgang Junger

(d) INSTITUTION'S NAME, ADDRESS, AND PHONE NO.
(Street, city, state, zip code)

Beth Israel Deaconess Medical Center / 330 Brookline Ave / Boston, MA 02215-5491