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 DK 7740-24

Type	Activity	ID Serial No.
5	T32	7740

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

Palchaudhuri, Sonali

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)*

☒ 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

10. PERMANENT MAILING ADDRESS

1549 S 16th Street
Philadelphia, PA 19146

9. ORCID ID: 0000-0002-2689-0553

E-mail: sonali.palchaudhuri@pennmedicine.upenn.edu

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

12. 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

13. 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

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

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

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

Enter a 3 digit code from instructions: 220

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

From: 07/01/2020 To: 06/30/2021

17. Education/Career Level: ☐ High School Student ☐ Undergraduate Student ☐ Post-baccalaureate ☐ Graduate Student ☒ Post-doctorate ☐ Faculty or Other Professional ☐ Post-master's

18. 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.		
Harvard University	AB	05/2007	biomechanical engineering	
University of Michigan	MD	05/2013		

PRIOR NRSA SUPPORT

Period of Support	Grant No.
07/01/2019 - 06/30/2020	5 T32 DK 7740-23

19. 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	
20. EXPECTED COMPLETION DATE FOR DEGREE(S) *(mm/yyyy, if applicable)*	
21. NAME OF SPECIALTY BOARDS *(if applicable)* Internal Medicine: Gastroenterology	

22. SUPPORT FOR PERIOD OF APPOINTMENT

Type	Total of this Grant *(Omit cents.)*	
Stipend /Salary / Other Compensation	$	61800
TOTAL	$	61800

23. 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.)*

24. 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 Electronically certified via eRA xTrain system by Trainee	(b) DATE 07/07/2020
25. 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 Electronically certified via eRA xTrain system by PI	(b) DATE 07/07/2020
(c) NAME OF PROGRAM DIRECTOR	Lewis, James D	
(d) INSTITUTION'S NAME, ADDRESS, AND PHONE NO. (Street, city, state, zip code)	UNIVERSITY OF PENNSYLVANIA Office of Research Services 3451 Walnut Street PHILADELPHIA, PA 191046205 Phone : 2158987293	

Notice of Award

CLINICAL INVESTIGATOR AWARD
Department of Health and Human Services
National Institutes of Health

Federal Award Date: 03/11/2020

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

Grant Number: 1K08DK120902-01A1
FAIN: K08DK120902

Principal Investigator(s):
Shazia Mehmood Siddique, MD

Project Title: Evaluation of variability in care and outcomes for patients with gastrointestinal bleeding