

University of Medicine and Pharmacy “Carol Davila” Bucharest
Department of Research, Development, and Innovation



“CAROL DAVILA” RESEARCH GRANTS 2025

PART D

Confirmation from the Host Institution’s Administrative Officer

Applicant:

(Full Name of the Applicant)

Instructions for the Applicant: Please fill in the name of the department where you intend to carry out your research activities. Submit this form together with PART A, PART B, and PART C to the appropriate Administrative Officer (e.g., Finance Officer, Registrar, Bursar, Secretary, Director) of the proposed host institution.

Administrative Officer: the above named candidate is applying for a “Carol Davila” Research Grant of the University of Medicine and Pharmacy “Carol Davila” Bucharest (UMPCD), Romania, to be used during a research period held at:

Department:

Institution:

An award under this scheme is typically administered through a fixed-term employment contract for the research period, established between the research grant recipient and the host institution. Should an award be granted, UMPCD will liaise with the host institution regarding the grant amount, starting date, and specific administrative arrangements. However, before the application can be formally considered, it is necessary to obtain confirmation that the host institution is, in principle, willing to offer an appointment to the candidate.

1. I confirm that if the above-named candidate is awarded a “Carol Davila” Research Grant, they will be offered an appointment by this institution for the research period in accordance with local social regulations and with the UMPCD terms and regulations.
2. The candidate will receive a grant of 2000 Euros maximum **per month** from the UMPCD, intended to cover running expenses and daily subsistence during the research period.
3. Health insurance coverage (including sickness and accident) for the candidate during the research period:

will be provided by the by the employing institution

the candidate is responsible for obtaining their own health insurance

Finance officer/Registrar/Bursar/Secretary/Director (Please delete as appropriate):

Full Name:

Institution:

Address:

Phone number:

Fax number (if applicable):

Email:

Contact Person for Grant Administration (if different from above):

Name:

Position:

Phone number:

Email:

Signature of the Administrative Officer: _____

Date: _____