

Clinician Research Fellowships 2023

Certification Form

1. Applicant

- (a) I confirm that I meet the eligibility criteria specified in Section 3 of the [CRF 2023 Guidelines and Conditions](#).
- (b) I am not currently and will not be during the period of the Fellowship, in receipt of paid research time greater than 0.3 FTE (including paid research time which is a component of an academic/clinical/administration role).
- (c) I agree to abide by the [CRF 2023 Guidelines and Conditions](#).
- (d) I declare information supplied by me on this form is complete and correct.

Full Name	
Signature	Date

2. Host Research Institution Representative

- (a) I confirm that adequate infrastructure and research support shall be provided to the applicant for the term of the Fellowship.
- (b) I am an authorised signatory for the Host Research Institution.

Full Name	
Position Title	
Institution	
Signature	Date

3. Research Mentor

- (a) I certify that I have reviewed the application and provided feedback to the applicant.
- (b) I confirm that I have provided a letter of support and that the applicant shall receive guidance and support in relation to this project during the term of their Fellowship.

Full Name	
Position Title	
Institution	
Signature	Date

4. Health Service Provider Institution Line Manager (Head of Department)

- (a) I confirm that the applicant is employed by the Health Service Provider institution, is undertaking clinical duties at a level not less than 0.3 FTE, and that this will continue for the duration of the Fellowship.
- (b) I confirm that the applicant may be released from their post for the period of the Fellowship and that their vacated post may be adequately back filled (if applicable).

Full Name	
Position Title	
Institution	
Email	
Signature	Date

5. Health Service Provider Institution Business Manager

Advice on the appropriate Business Manager for your Department/Service can be provided by your Department Administration, Medical Workforce, or the hospital intranet.

- (a) I confirm that the Budget Information and Budget Justification details contained in the Application Form are complete and correct.
- (b) I understand and agree that a claim will not be made on the WA Department of Health or the Raine Medical Research Foundation to cover any over-expenditure of budget.

Full Name	
Position Title	
Institution	
Email	
Signature	Date

6. Health Service Provider Institution Representative

Please refer to the *Instructions for Health Service Provider Institution Representative Certification* in the application form.

- (a) The Health Service Provider institution endorses this application, will administer the Fellowship and will abide by the [CRF 2023 Guidelines and Conditions](#).
- (b) The Raine Medical Research Foundation will be notified immediately of any changes to the information provided in this application, such as the applicant leaving the WA Health Service Provider institution, if these changes occur prior to the Fellowship being concluded.
- (c) I am an authorised signatory for the Health Service Provider institution.

Full Name	
Position Title	
Institution	
Signature	Date

7. Consumer(s)

- (a) I commit to taking part in the activities proposed in this application for the duration of the Fellowship if successful.
- (b) I agree to abide by the [CRF 2023 Guidelines and Conditions](#).

Full Name	
Signature	Date

Full Name	
Signature	Date

Full Name	
Signature	Date