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**Clinician Research Fellowships 2024**

**Certification Form**

1. Applicant
2. I confirm that I meet the eligibility criteria specified in Section 3 of the [*CRF 2024 Guidelines and Conditions*](http://rainefoundation.org.au/funding/clinician-research-fellowships/).
3. 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).
4. I agree to abide by the [*CRF 2024 Guidelines and Conditions*](http://rainefoundation.org.au/funding/clinician-research-fellowships/).
5. I declare that the information supplied by me on this form is complete and correct.

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| **Full Name** | |
| **Signature** | **Date** |

1. Host Research Institution Representative
2. I confirm that adequate infrastructure and research support shall be provided to the applicant for the term of the Fellowship.
3. I am an authorised signatory for the Host Research Institution.

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| **Full Name** | |
| **Position Title** | |
| **Institution** | |
| **Signature** | **Date** |

1. Research Mentor
2. I certify that I have reviewed the application and provided feedback to the applicant.
3. 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.

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| **Full Name** | |
| **Position Title** | |
| **Institution** | |
| **Signature** | **Date** |

1. Health Service Provider Institution Line Manager (Head of Department)
2. I confirm that the applicant at the time of commencement of the fellowship will be employed by the Health Service Provider institution and will be undertaking clinical duties at a level not less than 0.3 FTE, and that this will continue for the duration of the Fellowship (where not already in place, this will commence and continue for the period of the fellowship).
3. 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).

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| **Full Name** | |
| **Position Title** | |
| **Institution** | |
| **Email** | |
| **Signature** | **Date** |

1. 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.

1. I confirm that the Budget Information and Budget Justification details contained in the Application Form are complete and correct.
2. 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.

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| **Full Name** | |
| **Position Title** | |
| **Institution** | |
| **Email** | |
| **Signature** | **Date** |

1. Health Service Provider Institution Representative

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

1. The Health Service Provider institution endorses this application, will administer the Fellowship and will abide by the [*CRF 2024 Guidelines and Conditions*](http://rainefoundation.org.au/funding/clinician-research-fellowships/).
2. 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.
3. I am an authorised signatory for the Health Service Provider institution.

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| **Full Name** | |
| **Position Title** | |
| **Institution** | |
| **Signature** | **Date** |

1. **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 2024 Guidelines and Conditions*](https://www.rainefoundation.org.au/research/funding-opportunities/clinician-research-fellowships/).

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| **Full Name** | |
| **Signature** | **Date** |

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| **Full Name** | |
| **Signature** | **Date** |

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| **Full Name** | |
| **Signature** | **Date** |