**Clinician Researcher Training Program 2024-25**

# **Application Form**

##### Due by: 1:00 pm (AWST) Thursday 8 May 2025

* ***Please refer to the relevant*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities) ***which include application instructions.***
* ***Activity Leads are responsible for complying with internal deadlines and ensuring all certifications are complete prior to submission.***

## Activity title

Provide a title for your proposed PhD project.

|  |
| --- |
|  |

## Activity summary

Provide a **plain language** summary of the proposal, including the aims, objectives, significance and expected benefits to the health and/or wellbeing of the WA community and alignment of the project to the relevant HSP, PPP provider or private hospital research priority. This summary may be used for publicity purposes.

*[Maximum 250 words]*

|  |
| --- |
|  |

## Support package summary

The information provided below must align with the ‘Scholarship support package’ section of this form and the ‘Budget details’ table. All amounts must be excluding GST.

|  |  |
| --- | --- |
| Cash contributions requested  *advice should be sought from the* [*ATO*](https://www.ato.gov.au/individuals-and-families/income-deductions-offsets-and-records/income-you-must-declare/scholarships-prizes-and-awards/scholarship-payments#Workrequirement) *for scholarship payments which will differ based on part-time and full-time status.* ***This includes an allocation of up to $70,000 for project costs*** | **Full-time**  $350,000 for medical or dental  $300,000 nursing, midwifery and allied health  **Part-time (must be justified)**  $400,000 medical or dental  $330,000 nursing, midwifery and allied health |
| Other source funding  *must be $80,000* | $ |
| Project costs  *must be no more than $70,000* | $ |
| In-kind contributions  *For the Responsible Entity, must include provision of co-supervisor, PhD Fees, grant administration from Responsible Entity* | $ (in-kind) |
| Total Support Package | $ |

## Responsible Entity

|  |  |
| --- | --- |
| Name of Responsible Entity  *Entity which would administer grant funds*  *Must be a WA university* |  |
| ABN |  |
| Registered address  *Must have a physical and operational presence in WA* |  |
| Contact officer pre-award | Name:  Position:  Email:  Phone: |
| Contact officer post-award | Same as pre-award above  **or**  Name:  Position:  Email:  Phone: |

## Other source funding for this Activity

|  |  |
| --- | --- |
| Funding Organisation |  |
| Funding Scheme/Round  *(if applicable)* |  |
| Amount of funding requested  *(ex GST and $AUD)*  *must be $80,000* | $ |
| Scholarship partner agreement form provided | Yes |

## Activity Lead

Insert an abridged (two-page maximum) Curriculum Vitae (CV) which includes key research achievements over the last 5 years. CVs can be inserted at the end of this application form.

|  |  |
| --- | --- |
| Title (e.g. Dr, Ms) First name SURNAME |  |
| ORCiD  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  |
| Citizenship/residency status | Australian citizen  Australia permanent resident  New Zealand citizen  appropriate work visa |
| Primarily based in WA  *Confirm that you will physically reside in WA for a minimum of 80% during the grant* | Yes |
| For applicants who are not an Australian citizen or permanent resident | I have worked for at least 2 years in a clinical role in a WA HSP, PPP provider or private hospital |
| Has a minimum of 2 years full-time equivalent clinical experience in a medical (pre-consultant level), dental, allied health, registered nurse or midwifery profession | Yes |
| Primary telephone number |  |
| Primary email address |  |
| Completed the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course (or equivalent) | Yes No  If applicable, equivalent course name: |
| Completed the free online 30 minute [Consumer & Community Involvement and Grant Writing](https://cciprogram.org/consumer-community-involvement-and-grant-writing-e-course/) course (or equivalent) | Yes No  If applicable, equivalent course name: |
| CV attached  *Maximum two pages* | Yes |
| Has no overdue reports for any OMRI or FHRI Fund grant programs | Yes |

**Other employment and affiliations (including health service provider, public-private partnership provider and/or private hospital employment)**

List all the entities that the Activity Lead is employed by or has an affiliation with, other than the Responsible Entity or Employer listed above. Add rows if necessary.

|  |  |  |
| --- | --- | --- |
| **Entity** | **Position/Title** | **Paid** Y/N |
|  |  |  |
|  |  |  |

**Other information**

|  |  |
| --- | --- |
| Profession and position title |  |
| Clinician Profession  *Note: this is collected for statistical purposes only* | Allied health  Dentistry  Medical Practitioner  Nursing & Midwifery |
| If Medical Practitioner, Clinician stage | Resident  Registrar |
| Research career stage  *An Early-Career researcher has held their PhD for no more than 5 years from the date that their PhD was passed and a Mid-Career researcher no more than 10 years, as at the time of application, taking into consideration any career disruptions as defined in the* [*NHMRC Relative to Opportunity Policy*](https://www.nhmrc.gov.au/about-us/nhmrc-policies-and-priorities)  *Note: this is collected for statistical purposes only* | Early-Career  Mid-Career  Post Mid-Career  No postgraduate degree |
| Postgraduate research degree  *The nominated years since award of degree/years of research experience* | Honours  Masters by Research  None  Years since award of most recent degree: \_\_\_\_\_\_\_\_  If None, years of research experience: \_\_\_\_\_\_\_\_ |
| Within which area are you located | Perth metropolitan  Regional and remote |

## Supervisors

Provide details for each of the supervisors involved in the Activity. This will include a supervisor nominated by the Responsible Entity and a supervisor nominated by the employing HSP, PPP provider or private hospital.

To demonstrate the capacity of the supervisor and their suitability to oversee the Activity Lead, insert an abridged (two-page maximum) CV of each supervisor, which includes key research achievements, leadership and mentoring experience over the last 5 years. CVs must be inserted at the end of this application form.

Supervisors must provide a letter of support indicating their perspective on the motivation and potential of the Activity Lead to have a long career as a clinician-researcher and to become a leader in their field.

|  |  |
| --- | --- |
| **HSP/PPP provider supervisor** | |
| Title (e.g. Dr, Ms), First name, SURNAME |  |
| ORCiD  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  |
| Employer(s) |  |
| Position(s) |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| Primary telephone number |  |
| Primary email address |  |
| Completed the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course (or equivalent) | Yes No  If applicable, equivalent course name: |
| CV attached  *Maximum two pages* | Yes |
| Letter of support attached | Yes |

|  |  |
| --- | --- |
| **Responsible Entity supervisor** | |
| Title (e.g. Dr, Ms), First name, SURNAME |  |
| ORCiD  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  |
| Employer(s) |  |
| Position(s) |  |
| Role in this Activity |  |
| Time commitment to this Activity | hours/week |
| Primary telephone number |  |
| Primary email address |  |
| Completed the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course (or equivalent) | Yes No  If applicable, equivalent course name: |
| CV attached  *Maximum two pages* | Yes |
| Letter of support attached | Yes |

## Activity classification

|  |  |
| --- | --- |
| **Broad Research Area** *(select one)*  *Refer to National Health and Medical Research Council* [*website*](https://www.nhmrc.gov.au/about-us/resources/australian-standard-research-classifications-and-research-keywords?mc_cid=8d59f951bb&mc_eid=e758823e42) *for description of broad research areas.* | **​**  Basic scienceresearch  **​**  Clinical medicine and science research  **​**  Health services research  **​**  Public health research |
| Field of Research (FoR)  *Australian and New Zealand Standard Research Classification, 2020 downloadable from the Australian Bureau of Statistics* [*website*](https://www.abs.gov.au/statistics/classifications/australian-and-new-zealand-standard-research-classification-anzsrc/latest-release)*.* | Primary FoR *(mandatory):*   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |   Secondary FoR(s) *(optional):*   |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| **Burden of Disease** (up to 2) state the disease groups and names that are most applicable or have the highest burden  *Downloadable Australian Institute of Health and Welfare* [*Australian Burden of Disease Study*](https://www.aihw.gov.au/reports/burden-of-disease/abds-methods-supplementary-material-2018/data) *Table 2.1* | *e.g. Blood and metabolic disorders - Cystic fibrosis* |
| **Keywords** (up to 5)  *Must be selected from NHMRC*  [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Researcher > My Applications > Keyword Library* | 1.  2.  3.  4.  5. |

## Significance of the Activity (20%)

Applications must address contemporary challenges or needs as determined by the employing HSP, PPP provider or private hospital.

Describe the following:

1. the issue and its significance to the employing HSP, PPP provider or private hospital priorities and the broader WA health system (e.g. incidence, prevalence, burden of disease, impact on delivery or cost of health service)
2. how the proposed Activity will address the issue described above
3. the expected benefits to the WA health system (e.g. reduce inequities, improved efficiencies and cost savings, economic, social and environmental benefits)
4. the potential impact on clinical practice and other existing programs that are currently operating in this area

*[Maximum 500 words]*

|  |
| --- |
| a)  b)  c)  d) |

## Activity plan for the PhD project (20%)

Describe the Activity plan, including:

1. the Activity objectives, ensuring these are specific, measurable, attainable, relevant and time-bound
2. the methodology that will be followed, including techniques, target group(s), a realistic sample size, and how achievement of the Activity objectives will be demonstrated
3. a list of all locations where the Activity will be undertaken, ethics and governance approvals and agreements that will be required before the Activity can proceed (if any research is undertaken at a WA public health system site or involves a WA public health system employee, ethics approval must be sought from a WA Health HREC, as per the Department of Health [Research Governance Framework](https://rgs.health.wa.gov.au/Pages/Research-Governance-Framework.aspx))
4. demonstrated suitability of the supervisory team for the project
5. an achievable timeline.

*Note: Assessment of the Activity plan includes the achievability of the proposed milestones and timeframes (as provided below) and the proposed budget to undertake the Activity and justification for budget items (as provided in the ‘Budget request’ section).*

*[Maximum 2,000 words]*

|  |
| --- |
| a)  b)  c)  d)  e) |

List the major milestones for the Activity and their duration in months from Activity start date in the following table.

The Activity starts upon execution of a Grant Funding Agreement. Include separate milestones as applicable, for example, ethics and governance approvals, employment of staff, data collection, participant recruitment, and data analysis. Note dissemination of outcomes, e.g. publications, are not appropriate milestones, as they are not a component of the Activity.

*Note: If ethics/governance approval is required for the Activity, this must be achievable within the Activity period and approval dates do not affect the Activity start date.*

| **No** | **Milestone**  *(insert additional rows as required in order of completion)* | **Milestone date**  *(in months from start date)* |
| --- | --- | --- |
| 0. | Execution of Grant Funding Agreement | 0 months |
| 1. | *e.g. prepare and submit ethics application* | *e.g. 1 month from start date* |
| 2. | *e.g. recruitment of support personnel* | *e.g. 1 months from start date* |
| 3. | *e.g. obtain ethics and governance approvals* | *e.g. 6 months from start date* |
| 4. | *e.g. recruit first participant* |  |
| 5. | *e.g. recruit final participant* |  |
| 6. | *e.g. obtain final participant data* |  |
| 7. | *e.g. analyse data* |  |

|  |  |
| --- | --- |
| Enter the duration of the Activity in months  *(Activity must be completed within a maximum of 42 months\*)*  *Part time PhD completion may be allowed where justified. Part time candidates must complete the activity within 84 months.* | months |

## Activity Lead track record (15%)

Describe the following:

1. the Activity Lead’s contribution to translational research
2. the Activity Lead’s track record of influencing policy and/or practice
3. the Activity Lead’s educational, research and experience within the field of the proposed PhD project including technical skills and research related knowledge
4. the Activity Lead’s capacity and plan for meeting the deliverables (as outlined in the ‘Program description’ section of the Guidelines and Conditions).

With regards to a) and b), consideration must be given to the [NHMRC Relative to Opportunity Policy.](https://www.nhmrc.gov.au/about-us/nhmrc-policies-and-priorities)

*[Maximum 500 words]*

|  |
| --- |
| b)  c)  d) |

## Activity Lead potential (25%)

Describe the following:

1. the Activity Lead’s demonstrated commitment, expertise and motivation for a lasting clinical research career
2. the Activity Lead’s commitment, expertise and motivation to undertake the Activity
3. the Activity Lead’s career plan, including key milestones for achieving an independent and self-sustaining career in WA and broader translational research interests
4. if a part-time option has been selected, provide a justification for the request. It is intended that applicants undertake a PhD full-time. An exception to this may be considered where adequate justification is made to support equitable opportunities.

With regards to a), b) and c) letters of support from nominated supervisors will be considered.

*[Max 500 words]*

|  |
| --- |
| a)  b)  c)  d) |

## Consumer involvement (10%)

Describe the following:

1. how consumers (people with lived experience of a health issue, including patients and potential patients, carers and people who use health care services) have been involved in the development of the proposed Activity
2. the plan for ongoing consumer engagement in the Activity, including their roles and how their lived experience perspectives will inform the Activity through formal and informal processes.

Refer to the ‘Consumer involvement’ section of the Guidelines and Conditions. Note it is recommended that all team members complete the free online 30 minute [Consumer and Community Involvement in Health Research](https://retprogram.org/training/consumer-and-community-involvement-in-health-research/) course (or equivalent) and that the Activity Lead also completes the free online 30 minute [Consumer & Community Involvement and Grant Writing](https://cciprogram.org/consumer-community-involvement-and-grant-writing-e-course/) course before completion of this section.

As an example for clarity, if the Activity relates to the trialling of a healthcare service provided by clinicians for patients to be used by a clinician on a patient, the clinician is not a consumer for the purposes of this application, but rather the patient or their carer are consumers.

*[Maximum 500 words]*

|  |
| --- |
| a)  b) |

Please provide details of each consumer representative involved in the development of this proposal and/or proposed to be involved in the Activity. Note that named consumers must be aware of and agree to the statements above and must provide certification if proposed to be involved in the Activity.

Insert tables as required.

|  |  |
| --- | --- |
| Full name |  |
| Email address |  |
| Role in the development of this proposal (if applicable) |  |
| Role in this Activity  (if applicable) |  |

## Translation and implementation (10%)

Describe the following:

1. planned steps for the translation and/or implementation of findings and the Activity timeframes for translational impacts
2. how the knowledge, expertise and experience of the Activity Lead and supervisors will assist with the process of translating findings into policy and/or practice
3. future plans for the Activity. For example, a possible extension of the Activity to a broader geographical area, population or to other disciplines.

*[Maximum 1000 words]*

|  |
| --- |
| a)  b)  c) |

## Budget details for project costs

1. Non-salary costs:
   1. *Must only include essential services, supplies, unique equipment, consumer involvement and other expenses directly related to the Activity.*
   2. *Travel will not be approved unless strongly justified as being essential to the undertaking of the Activity and must not include costs related to conference attendance.*
   3. *Equipment items must not exceed a total value of the budget request or $15,000, whichever is the lesser amount, and quotes for items must be attached to the application.*

If part-time, insert columns as needed.

| **Budget category and item description** | **Year 1 request**  (AUD ex GST) | **Year 2 request**  (AUD ex GST) | **Year 3 request**  (AUD ex GST) | **Year 4 request**  (AUD ex GST)  (6 months) |
| --- | --- | --- | --- | --- |
| 1. **Non-salary costs**   *Insert more rows if required* |  |  |  |  |
| Supplies:  *(provide details of items required)* | $ | $ | $ | $ |
| Consumer involvement:  *(provide details)* | $ | $ | $ | $ |
| Equipment:  *(provide details and attach quotes)* | $ | $ | $ | $ |
| Information technology:  *(provide details of non-standard items required)* | $ | $ | $ | $ |
| Travel:  *(provide travel purpose, dates and location)* | $ | $ | $ | $ |
| Other:  *(specify each item)* | $ | $ | $ | $ |
| ***Total non-salary costs***  *(can be up to $70,000)* | ***$*** | ***$*** | ***$*** | ***$*** |

### Budget request justification

Provide a justification for all requested budget items, such as specific expertise or equipment, and where this expenditure is not in WA, explain if the item is not available in WA or if it is beneficial to WA for the item to be procured outside the State. For equipment items ensure quotes are attached.

*[Maximum 250 words]*

|  |
| --- |
|  |

## Bibliographic references

If applicable, provide bibliographic references to any publications or reports cited in the application. Please only include publications strictly pertinent to the application.

|  |
| --- |
|  |

## Assessors not to be approached

Provide the name(s) of any assessor(s) you request not to be approached to assess this application (if applicable) to [DOH.OMRI@health.wa.gov.au](mailto:DOH.OMRI@health.wa.gov.au). This information will only be available to the Office of Medical Research and Innovation, and must be provided by the application closing date.

## Activity Lead certification

I certify that:

1. I commit to undertaking the Activity proposed in this application for the duration of the grant if successful
2. the information supplied by me on this form is complete, true and correct in every particular
3. I agree to abide by the *Guidelines and Conditions*
4. I agree to participate in an evaluation whether the application is successful or unsuccessful
5. I have discussed the likely impact of the Activity on participating organisations, and this Activity is acceptable to them
6. I agree to obtain any research ethics and governance approvals that might be required for undertaking the funded Activity
7. I understand and agree that if the application is successful, that no further claim will be made on the Department of Health to cover any expenditure beyond the approved budget
8. if the Activity Lead is employed by an HSP (includes Clinical Academics where applicable), the Activity Lead will [register](http://coi.hdwa.health.wa.gov.au/) a Conflict of Interest for this grant in accordance with the Department of Health [Managing Conflicts of Interest Policy](https://www.health.wa.gov.au/About-us/Policy-frameworks/Integrity/Mandatory-requirements/Managing-Conflicts-of-Interest-Policy) that addresses how the Activity Lead intends to ensure WA Health intellectual property (IP) is protected
9. I am not in receipt of other scholarships to undertake a PhD
10. I do not have overdue reporting obligations for any grant funding program administered by the Office of Medical Research and Innovation (including FHRI Fund programs) from any year (excludes authorised extensions)
11. I will advise if any other funding is awarded for any component of the Activity.

### Activity Lead

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

## Supervisor certification

We certify that:

1. we commit to supervising the Activity Lead and their Activity proposed in this application for the duration of the grant if successful
2. the information supplied by us on this form is complete, true and correct in every particular
3. we agree to abide by the *Guidelines and Conditions*
4. we agree to participate in an evaluation whether the application is successful or unsuccessful
5. we agree to obtain any research ethics and governance approvals that might be required for undertaking the funded Activity
6. we understand and agree that if the application is successful, that no further claim will be made on the Department of Health to cover any expenditure beyond the approved budget.

### HSP/PPP provider supervisor

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

### Responsible Entity supervisor

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

## Scholarship partner

I certify that:

1. I am an authorised representative of the organisation
2. I confirm that the organisation is willing to provide an in-principle cash co-contribution for the scholarship support package, subject to the success of the application and availability of funds.

### Scholarship partner

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

## Consumer representative certification

I certify that:

1. I commit to taking part in the Activity proposed in this application for the duration of the grant if successful
2. I agree to abide by the *Guidelines and Conditions*
3. I agree to be contacted in relation to the grant, e.g. for evaluation of the grant funding program.

Insert additional tables as required.

### Consumer Representative 1

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

## HSP/PPP provider/private hospital representative endorsement

I certify that:

1. I am an authorised representative of the employing HSP/PPP provider/private hospital
2. I endorse the Activity outlined in this proposal, and confirm that it is aligned to the established strategic and health priorities outlined by the HSP/PPP provider/private hospital I represent
3. an appointment of 0.2 FTE (or 0.5 FTE if enrolled part-time) will be offered to the Activity Lead at my HSP/PPP provider/private hospital for the duration of their scholarship
4. the Department of Health will be notified immediately of any changes to employment circumstances of the Activity Lead and eligibility conditions originally provided in this application.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Position** |  | | |
| **Signature** |  | **Date** |  |

## Responsible Entity certification

I certify that:

1. I am an authorised representative of the Responsible Entity
2. all the eligibility criteria listed in the *Guidelines and Conditions* are met
3. the Activity Lead has secured a PhD course offer from the Responsible Entity, conditional on them receiving a scholarship
4. the Responsible Entity endorses this application and confirms that the information supplied on this form is complete, true and correct in every particular
5. the Responsible Entity is willing to administer the grant if successful under the conditions specified in the *Guidelines and Conditions*, including the requirement to ensure that  
   appropriate agreements are in place with the Activity Lead, team members and participating entities
6. the grant will not constitute the entire financial base of the Responsible Entity, i.e. the Responsible Entity has other external sources of income
7. the Responsible Entity or other entities that fund or are involved in the Activity are not part of an industry that produces products or services that may contribute to poor physical health or mental wellbeing of the community
8. the Department of Health will be notified immediately of any changes to eligibility or changes to the information originally provided in this application.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name** |  | | | |
| **Position** |  | | | |
| **Signature** |  | **Date** |  |

## Responsible Entity finance officer (or equivalent) certification

I certify that:

1. I am an authorised finance representative of the Responsible Entity
2. the budgeted costs in this application are true and correct and reflect the latest costing information available to me
3. amounts requested in the Budget are in Australian dollars and are exclusive of Australian GST
4. I understand that funding will only be made available for the scope of work described in the application, or any modifications to the scope of work approved in writing by the Department of Health. The Department of Health is not obliged to underwrite any costs beyond funding awarded through this Program.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Position** |  | | |
| **Signature** |  | **Date** |  |

**[Scan this QR code with your smart phone to go the WA Health website](http://www.health.wa.gov.au/)**

**This document can be made available in alternative formats   
on request for a person with a disability.**

© Department of Health 2024

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.