**Clinician Researcher Training Program**

**2022-23**

# **HSP/PPPP Application Form**

**Application Period closes: 1:00pm (AWST), Tuesday 31 January 2023**

***When completing this Application Form refer to the*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities)***, which include application instructions.***

**Submission Instructions:**

1. This form is to be completed by an authorised representative of the relevant Health Service Provider (HSP) / public-private partnership provider (PPPP) and submitted to the Office of Medical Research and Innovation as per the application instructions in the *Clinician Researcher Training Program Guidelines and Conditions*
2. Project proposals selected by the relevant HSP/PPPP must be attached when submitting this Application Form

## HSP/PPPP Name

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## Higher Degree by Research (HDR) Approved Projects

List approved HDR projects (one for each profession), noting that the WA Country Health Service (WACHS) is eligible to submit an additional 2 projects from any profession.

**Note: Approved project proposals must be included as attachments to this application.**

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| Approved HDR Project – Pre-consultant (Medical) |
| HDR project title |  |
| Administering institution |  |

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| --- |
| Approved HDR Project – Allied Health |
| HDR project title |  |
| Administering institution |  |

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| --- |
| Approved HDR Project – Nursing and Midwifery |
| HDR project title |  |
| Administering institution |  |

*WACHS to duplicate relevant tables for additional projects*

## Health Service Provider certification / Public-Private Partnership Provider

I certify that:

1. I am an authorised representative of the HSP/PPPP
2. the projects submitted in this application have been approved by the HSP/PPPP
3. the HSP/PPPP will collaborate with the administering institution to undertake a competitive recruitment process to select the most suitable candidate for the HDR project
4. the HSP/PPPP will negotiate in good faith with the successful candidate to facilitate the conduct of the HDR project and their clinical duties (if applicable) for the duration of the scholarship
5. I understand that funding will only be made available for the candidate’s stipend at the level agreed by the Department of Health for the duration of the HDR degree
6. the Department of Health is not obliged to underwrite any recurrent or capital costs beyond funding awarded through this Program.

|  |  |
| --- | --- |
| **Title, First Name, SURNAME** |  |
| **Position** |  |
| **Signature** |  |
| **Date** |  |
| **Telephone number** |  |
| **Email address** |  |

## Administering institution representative certification

I certify that:

1. I am an authorised representative of the administering institution
2. the administering institution endorses the projects in this application, confirms that the information supplied on this form, is complete, true and correct in every particular and is willing to administer the funding under the conditions specified in the *Clinician Researcher Training Program Guidelines and Conditions*
3. the administering institution agrees to contribute stipend support and student fee-offset scholarship for the relevant projects, at the FTE indicated, as outlined in the *Clinician Researcher Training Program Guidelines and Conditions*
4. the administering institution, in collaboration with the HSP/PPPP will undertake a competitive recruitment process to select the most suitable candidate for the HDR project in accordance with conditions and criteria specified in the *Clinician Researcher Training Program Guidelines and Conditions*
5. I confirm that once recruitment of HDR candidates is completed, a selection report outlining the selection process used and providing candidate details including clinical profession, salary details, ORCID iD, HDR training stream and proposed start date, must be submitted to the Department of Health
6. I understand that funding will only be made available for the agreed stipend contribution approved by the Department of Health. The Department of Health is not obliged to underwrite any recurrent or capital costs beyond funding awarded through this Program
7. the Department of Health will be notified immediately of any changes to the information originally provided in this application.

|  |  |
| --- | --- |
| **Administering Institution Name** |  |
| **Title, First Name, SURNAME** |  |
| **Position** |  |
| **Signature** |  |
| **Date** |  |
| **Telephone number** |  |
| **Email address** |  |

*Duplicate table as required*

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