**Clinician Researcher Training Program**

**2022-23**

# **HDR Project Proposal Form**

**When completing this Project Proposal Form, please refer to the *Clinician Researcher Training Program*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities) **for information related to the program conditions and application process**

**Submission Instructions:**

1. This project proposal form should be completed by the potential HDR supervisory team.
2. Contact the relevant Health Service Provider (HSP) / public-private partnership provider (PPPP) research office or equivalent to determine submission requirements (i.e. internal deadlines and submission address).
3. The completed form including all certifications must be submitted to the relevant HSP/PPPP in line with their submission requirements.

## HSP/PPPP Name

|  |
| --- |
|  |

## Administering Institution

|  |  |
| --- | --- |
| Name of administering institution (host university)  *WA university where candidate would be enrolled and which would administer grant funds* |  |
| Contact officer name |  |
| Contact officer position title |  |
| Contact officer email address |  |

## HDR Project Description

|  |  |
| --- | --- |
| Clinical profession | i.e. Pre-consultant (Medical) / Allied Health / Nursing and Midwifery |
| HDR project title |  |
| HDR project clinical area |  |
| 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 (select one disease)  *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* |  |
| Research Keywords (up to 5)  *Available from NHMRC*  [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Research > My Applications > Keyword Library* | 1.  2.  3.  4.  5. |
| Describe how the project aims to advance clinical practice in the relevant field  *Maximum 100 words* |  |
| Proposed HDR Project Summary (may be used for publicity purposes) | |
| Aims:  *Maximum 100 words* | |
| Objectives:  *Maximum 100 words* | |
| Significance:  *Maximum 100 words* | |
| Expected outcomes:  *Maximum 100 words* | |
| Expected benefits for WA health system:  *Maximum 100 words* | |
| Consumer Involvement:  *Describe how consumers have been and will be involved in the development of the HDR project.*  *Refer to Section 9 of the Guidelines and Conditions.*  *Maximum 100 words* | |
| Describe how the HDR project aligns with your HSP / PPPP strategic and / or health priorities:  *Maximum 100 words* | |
| Preferred HDR stream  *Actual pathway will be subject to recruitment of candidate and university approval* | PhD  Masters  Either |
| Preferred HDR Candidate FTE  *Actual FTE will be subject to recruitment of candidate and HSP/PPPP and university approval* | 0.5 FTE  1.0 FTE  Either |
| Research Foundation partner support (if applicable) |  |

## Supervisory Team

Provide a summary of the proposed supervisory team

|  |  |
| --- | --- |
| HDR project supervisory team | |
| HSP / PPPP supervisor name |  |
| HSP / PPPP supervisor position |  |
| HSP / PPPP supervisor department |  |
| HSP/PPPP supervisor ORCID iD |  |
| HSP / PPPP supervisor email address |  |
| University principal supervisor name |  |
| University principal supervisor position |  |
| University principal supervisor department |  |
| University principal supervisor ORCID iD |  |
| University principal supervisor email address |  |
| *Add additional lines for additional Supervisory Team members* |  |
| Suitability of supervisory team for proposed project  *Describe how the knowledge, expertise and experience of the supervisory team is appropriate for the proposed HDR project*  *Maximum 200 words* |  |
| Potentially suitable candidates for the proposed project have been, or are likely to be, identified. | Yes  No  Unsure |

## Supervisory team certification

We certify that:

1. we commit to supporting the proposed project for the duration of the HDR
2. the information supplied by us on this form is complete, true and correct in every particular
3. we agree to abide by the *Clinician Researcher Training Program Guidelines and Conditions*
4. we agree to obtain any research ethics and governance approvals that might be required for undertaking funded activities
5. subject to approval of project, candidates will be recruited in accordance with conditions and criteria specified in the *Clinician Researcher Training Program Guidelines and Conditions*
6. we understand and agree, that should the project be approved, no further claim will be made on the Department of Health to cover any expenditure beyond the approved stipend contribution for the successful candidate
7. no member of the supervisor team has overdue reporting obligations for any other funding programs administered by the Office of Medical Research and Innovation (including Future Health Research and Innovation Fund Programs).

**University Principal Supervisor**

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

**HSP / PPPP Supervisor**

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

## Administering Institution Head of Graduate Research School or equivalent certification

I certify that:

1. the supervisory team include suitably qualified and registered supervisors for the proposed HDR project
2. the administering institution endorses the proposed HDR project at the FTE indicated, and should the project be approved, agrees to administer the funding under the conditions specified in the *Clinician Researcher Training Program Guidelines and Conditions*

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

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

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