**Major Research and Innovation Application Support Round 5**

# **Application Form**

##### Due by: 1:00 pm (AWST) Thursday 12 June 2025

* ***Please refer to the relevant*** [***Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities) ***for Program instructions.***
* ***Please refer to the*** [***application submission user guide***](https://fhrifund.health.wa.gov.au/Funding/GMS-link-page) ***for instructions on how to complete and submit this application form.***
* ***Activity Leads are responsible for complying with internal deadlines and ensuring all certifications are complete prior to submission.***

## Activity title

The Major Research and Innovation Application Support (MRIAS) application should have the same title as the planned application to the External Program.

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## 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. This summary may be used for publicity purposes.

*[Maximum 250 words]*

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## Funding request

The information provided below must align with the ‘Budget request’ table. All amounts must exclude GST.

|  |  |
| --- | --- |
| A. MRIAS co-funding cash request  *Less than or equal to $1,000,000* | $ |
| B. Funding requested from the External Program funding body | $ |
| C. Other partner cash contributions to be included in the External Program application | $ |
| Confirm that (B) Funding requested from the External Program funding body + (C) Other partner cash contributions is greater than or equal to the MRIAS co-funding cash request (A) | **Yes**  (B + C ≥ A) |

## Responsible Entity

|  |  |
| --- | --- |
| Name of Responsible Entity  *Entity which would administer grant funds.*  *Must be considered an eligible entity in accordance with the External Program’s definition.* |  |
| ABN |  |
| Registered address  *Must have a physical and operational presence in WA* |  |
| Contact officer pre-award  *Officer responsible for application (must be different to the Activity Lead)* | Name:  Position:  Email:  Phone: |
| Contact officer post-award  *Officer responsible for grant administration (must be different to the Activity Lead)* | Same as pre-award above  **or**  Name:  Position:  Email:  Phone: |

## Activity Lead

Insert an abridged (two-page maximum) Curriculum Vitae (CV) which includes key research and/or innovation 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 (if relevant)  *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 |
| Will the Activity Lead physically reside in WA for a minimum of 80% during the grant period | Yes No |
| 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)  *Note: Although this training is for ‘research’ it contains insights which also have relevance to innovation activities* | 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 |

**Grant Arrangement**

|  |  |
| --- | --- |
| Relationship to Responsible Entity  *Refer to ‘Eligibility’ section of the Guidelines and Conditions* | (a) employee of the Responsible Entity  or  (b) honorary or adjunct title at the Responsible Entity |
| If response to grant arrangement is (a), indicate further details | Position at Responsible Entity: |
| If response above is (b) and there will be an arrangement with an Employer, indicate further details | Title at Responsible Entity:  honorary  adjunct |
| Intended grant arrangement:  affiliation agreement  subcontract to Employer |
| Employer: |
| Position at Employer: |
| Employer has an active ABN:  Yes |
| Employer has a physical & operational presence in WA:  Yes |

**Other employment and affiliations**

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. Identify if this involves an adjunct or honorary title or a Clinical Academic position. Add rows if necessary.

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

|  |  |
| --- | --- |
| Discipline/Profession |  |
| Clinician Profession  *Note: this is collected for statistical purposes only* | Allied health and health sciences  Dentistry  Medical Practitioner  Nursing & Midwifery  Not-clinician (not applicable) |
| 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  Not postgraduate degree (not applicable) |
| Postgraduate research degree  *The nominated years since award of degree/years of research experience must align with the justification below.* | PhD  Masters by Research  None  Years since award of degree: \_\_\_\_\_\_\_\_  If None, years of research experience: \_\_\_\_\_\_\_\_ |
| Within which area are you located | Perth metropolitan  Regional and remote |

## Team members

Provide details for each of the team members involved in the Activity. This will include team members associated with the Responsible Entity, and any other participating organisations.

To demonstrate the capacity of the team and its suitability to conduct the Activity, insert an abridged (two-page maximum) CV of each team member, which includes relevant key achievements over the last 5 years. CVs can be inserted at the end of this application form.

Insert additional team member tables as required.

|  |  |  |
| --- | --- | --- |
| **Team member 1** | | |
| Title (e.g. Dr, Ms), First name, SURNAME |  | |
| ORCiD (if relevant)  *An ORCiD can be generated for free at* [*https://orcid.org/*](https://orcid.org/) |  | |
| 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)  *Note: Although this training is for ‘research’ it contains insights which also have relevance to innovation activities* | Yes No  If applicable, equivalent course name: | |
| CV attached  *Maximum two pages* | Yes | |
| Employer(s) | Position(s) and Title(s) | Paid  Y/N |
|  |  |  |
|  |  |  |
|  |  |  |

## External Program

When completing the table below, supporting information must be provided as instructed.

|  |  |  |
| --- | --- | --- |
| Name of External Program funder  *Entity which administers the External Program* |  | |
| Name of External Program to be applied to |  | |
| The Activity Lead is the: | Lead applicant  *(i.e. Coordinating Principal Investigator (CPI), Chief Investigator A or equivalent) on the External Program application*  Co-lead on the External Program application for a large multi-jurisdictional application | |
| Did the External Program application process include an Expression of Interest or shortlisting stage | Yes No  If yes, please attach a copy of the correspondence indicating you were successful at this stage | |
| External Program closing date  *The External Program closing date is no less than 6 weeks and no more than twelve months from this applications closing date* | Full application closing date:  Yes | |
| Expected External Program award notification date |  | |
| Expected External Program funding commencement date and duration |  | |
| When is MRIAS funding required by the External Program funder?  *Date(s) or payment schedule* |  | |
| Any requirements or other relevant conditions for applying to the External Program  *e.g. a policy or practice partner is required* |  | |
| Is a letter of support required from the Department of Health?  When is the Department of Health letter required?  Is a specific format or template required?  If yes, I have attached the template. | Yes  Letter of support/commitment due date:  Yes  No  Yes  N/A | |
| Is the External Program listed in the Guidelines and Conditions as an Eligible External Program?  If yes, I have attached a copy of the External Program guidelines  If no, I have attached an MRIAS External Program Eligibility Form, the External Program guidelines and the approval email from OMRI. | | Yes  No  Yes  Yes |
| Is the project health and medical research or innovation?  *Refer to the definition in the Guidelines and Conditions* | | Yes |
| Is the total expected expenditure in WA provided through the External Program at least double the MRIAS contribution being requested?  *(For example, if the MRIAS cash commitment requested is $1 million, at least $2 million in total must be spent in WA)*  *Confirm the above by ticking ‘Yes’ and provide the exact dollar values* | | Yes  MRIAS co-funding contribution request $  Total expected expenditure in WA $ |
| Is a WA organisation a named partner on the External Program application?  *Describe the WA organisation and its role in the External Program application* | | Yes |
| Other organisations partnering on the External Program application are not part of an industry that produces products or services that may contribute to poor physical health or mental wellbeing of the community.  *List the partner organisations* | | Yes  Partner organisations: |

## Activity classification

|  |  |
| --- | --- |
| **For applications to *research* External Programs**  **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  Not applicable (innovation External Program) |
| For applications to *research* External Programs  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):*   |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |   Not applicable (innovation External Program) |
| **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*  *Note: this source of keywords is used for consistency across grant reporting and is applicable to all applications* | 1.  2.  3.  4.  5. |

## Competitiveness for External Program funding (40%)

Describe here how the application addresses the External Program’s assessment criteria.

1. List below each of the External Program’s assessment criteria and your response to these.
2. Criteria related to the Activity plan, methodology and timeframes should be included in the Activity Plan section of this form at Section 9a.
3. Criteria related to Budget should be included in the Budget section of this form at Section 9b – 9e.
4. At a minimum, your responses should address the following areas:
   * Activity quality, feasibility, novelty
   * Benefits and/or impacts
   * Collaborations, partnerships or alliances
   * Track record of the team (note CVs must be attached for each team member)
   * Governance, identified risks and plan for sustainability.

*[Maximum 500 words per criterion]*

|  |
| --- |
| **External Program Assessment Criteria** (insert additional rows as required) |
| **Criterion 1:** *(delete this text and insert name of External program criterion here)* |
|  |
| **Criterion 2:** *(delete this text and insert name of External program criterion here)* |
|  |
| **Criterion 3**: *(delete this text and insert name of External program criterion here)* |
|  |
| **Criterion 4:** *(delete this text and insert name of External program criterion here)* |
|  |

## a) Activity plan

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, how achievement of the Activity objectives will be demonstrated, measures of outcomes, approvals, milestones and novel approach
3. a list of all locations where the Activity will be undertaken, ethics and governance approvals (if applicable) and agreements that will be required before the Activity can proceed
4. the proposed, achievable timeline.

*[Maximum 400 words]*

|  |  |
| --- | --- |
| i)  ii)  iii)  iv) | |
| Enter the duration of the Activity in months  *(Activity must be completed within a maximum of 72 months)* |  |

## b) MRIAS Budget request

The cash co-funding amount requested in the MRIAS application can be up to $1 million (excluding GST) per application, paid over a period of up to 6 years.

Requested FTE, salary level, costs and duration must reasonably reflect the proposed Activity and be directly attributable to the delivery of the proposed Activity.

The requested MRIAS co-funding cash amount cannot exceed the total amount of the cash amount requested from the External Program and other partner cash contributions (combined). In-kind contributions are excluded from this amount.

The amount requested from MRIAS, partners and the External Program must allow for expenditure in WA to be at least double the MRIAS funding amount requested.

List requested budget items in the table below, noting the following:

1. Salary costs:
   1. *May include Award/Agreement increases and salary increments as appropriate.*
   2. *May include superannuation, payroll tax and worker compensation as on-costs up to a maximum of 30%, noting that WA public health system salaries can only include superannuation as a salary on-cost.*
   3. *Are not to provide salary for the Activity Lead. An exemption to this rule may be requested, where it is deemed that this salary is crucial to the success of the Activity. Adequate justification must be provided. Determination of exemptions will be made on a case-by-case basis, at the discretion of the OMRI.*
2. Non-salary costs:
   1. *Must only include essential services, supplies, unique equipment and consumer involvement.*
   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 10% of the budget request or $15,000, whichever is the lesser amount, and quotes for each item must be attached to the application.*
3. Overhead charges:
   1. *Overhead charges (also referred to as indirect/infrastructure costs, e.g. utilities) may be requested up to a maximum 10% of the total budget, noting that WA public health system Responsible Entities cannot claim overheard charges in accordance with the Financial Management Manual s522 (grant funding administered by OMRI is exempt).*

| **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) | **Year 5 request**  (AUD ex GST) | **Year 6 request**  (AUD ex GST) |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Salary costs**   *Insert more rows if required* |  |  |  |  |  |  |
| Position title/role:  On-cost % (maximum 30%): | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ |
| Position title/role:  On-cost % (maximum 30%): | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ | Base salary: $  On-costs: $ |
| ***Subtotal salary costs*** | ***$*** | ***$*** | ***$*** | ***$*** | ***$*** | ***$*** |
| 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)* | $ | $ | $ | $ | $ | $ |
| ***Subtotal non-salary costs*** | ***$*** | ***$*** | ***$*** | ***$*** | ***$*** | ***$*** |
| 1. **Overhead charges**   *Up to a maximum of 10% of costs (1 + 2)* |  |  |  |  |  |  |
| *(provide details here of how overheads are calculated)* | $ | $ | $ | $ | $ | $ |
| **TOTAL (1+2+3)**  *Must be less than or equal to $1,000,000 ex GST* | **$** | **$** | **$** | **$** | **$** | **$** |

### c) Budget request justification

Provide a justification for requested budget items listed in the table above, for example, specific expertise or equipment, and where this expenditure is not in WA explain why this is necessary. Travel costs must be strongly justified as being essential to the undertaking of the activity. If salary costs for the Activity Lead is included provide justification of how paying this salary is crucial to the success of the Activity (see note 1.4 above).

*[Maximum 500 words]*

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### d) Total indicative budget

Please provide in the table below the total indicative budget for the project, excluding GST. Include all funding sources in this budget (including funding being sought from MRIAS).

|  |  |  |
| --- | --- | --- |
| **Budget category**  *If there are multiple items in a category below create a separate row for each* | **Cash**  **($ excl GST)** | **In-kind**  **($ excl GST)** |
| *Item 1*  *e.g. Consumer involvement - stakeholder training, honoraria and payments, consultations and/or events etc* |  |  |
| *Item 2* |  |  |
| *Item 3* |  |  |
| *Item 4* |  |  |
| **Total Excluding GST** | **$** | **$** |

### e) Other funding sources for this Activity

Please select one of the two options below:

I have no other current source of funding for any component of this Activity, and no funding applications planned or in progress for any component of this Activity; or

I have funding applications planned or in progress which overlap with the entirety of this Activity or a component of this Activity (details below).

*For multiple funding applications, please provide each in a separate table*.

|  |  |
| --- | --- |
| Funding Organisation |  |
| Funding Scheme/Round |  |
| Amount of funding requested  (ex GST and $AUD) |  |
| Describe the overlap with this Activity |  |
| Expected date of Award or Decision |  |

## Significance of the Activity for WA (40%)

Applications must address contemporary challenges or needs faced by the WA health system and health and medical research and innovation sector.

Describe the following:

1. the significance of the issue or opportunity for WA (relevance/scale).
2. how the proposed Activity will address the issue or opportunity.
3. potential to build WA capability and capacity in research and/or innovation.
4. the expected benefits to the WA community (e.g. reduced inequities, improved health outcomes, economic, social and environmental benefits).
5. potential for translation and implementation of findings into policy, practice and/or the development of new processes, products and/or services, and commercialisation, if applicable.

*[Maximum 500 words]*

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

## Alignment with FHRI Fund Focus Areas (10%)

Describe how the primary purpose of the application directly addresses Aboriginal[[1]](#footnote-2) health issues, regional WA health issues, burden of disease, living with COVID-19 or Long COVID or mental health. If this is not applicable, leave this section blank.

*[Maximum 400 words]*

|  |
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## 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. It is recommended encouraged 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.

*\* Although this training is for ‘research’ it contains insights which also have relevance to innovation activities.*

For example, if the Activity relates to the trialling of a healthcare service provided by clinicians for patients or the development of a new medical device to be used by clinicians on patients, the clinician is not considered to be a consumer for the purposes of this application. Rather, the patient or the patient’s 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) |  |

## Bibliographic references and cited information

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

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## Assessors not to be approached

Provide the name(s) of any assessor(s) or organisation(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.

## Team certification

We certify that:

1. we commit to taking part in the 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 have discussed the likely impact of the Activity on participating organisations, and this Activity is acceptable to them
6. we have relevant permissions to use any third-party intellectual property required to deliver the Activity and have Freedom to Operate for this Activity
7. we agree to obtain any research ethics and governance approvals that might be required for undertaking the funded Activity
8. 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
9. if the Activity Lead is employed by the WA public health system and the Responsible Entity is not the WA public health system entity (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
10. the Activity Lead does 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. we will advise if funding is awarded for any component of the Activity.

### Activity Lead

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

Other Team Members associated with the Responsible Entity and any other participating organisations.

*Insert additional tables as required.*

### Team Member 1

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |  |

## 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 will have a position or title at the Responsible Entity for the period of the MRIAS and External Program grant if successful
4. if the Activity Lead is not an employee of the Responsible Entity, evidence of an affiliation agreement with, or in-principle agreement for subcontracting to, the relevant Employer has been attached, where this evidence has not previously been provided to the Office of Medical Research and Innovation
5. the Responsible Entity endorses this application and confirms that the information supplied on this form is complete, true and correct in every particular
6. the Responsible Entity will coordinate the major External Program funding application and 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
7. the grant will not constitute the entire financial base of the Responsible Entity, i.e. the Responsible Entity has other external sources of income
8. 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
9. 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/)**

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1. Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community. [↑](#footnote-ref-2)