**WA Near-miss Awards: Emerging Leaders 2024-25**

# **Application Form**

**Due by: 1:00 pm (AWST) Friday 13 December 2024**

* ***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.***

## NHMRC near-miss application details

|  |  |
| --- | --- |
| Application title (the ‘Activity’) |  |
| NHMRC Application Number |  |
| NHMRC Program and Stream |  |
| Duration of NHMRC grant applied for |  |
| NHMRC Application Score  *Please list all decimal places.* |  |
| NHMRC Application attached? | Yes |

## Activity summary

Provide a **plain language** summary of the proposal, including the aims, objectives, significance and expected benefits to the health and wellbeing of the WA community. This summary may be used for publicity purposes.

*[Maximum 250 words]*

|  |
| --- |
|  |

## NHMRC Investigator Grant funding request summary

The information provided below must align with the original application request to the NHMRC. All amounts must be excluding GST.

|  |  |
| --- | --- |
| NHMRC FTE requested  *Must be at least 0.5 FTE* | FTE:  If a WANMA Fellowship is awarded will this FTE be the same:  Yes No  If no, what is the new FTE: |
| NHMRC salary funding request | Salary $  Research support package $ |
| Total NHMRC funding request | $ |

## Responsible Entity

|  |  |
| --- | --- |
| Name of Responsible Entity  *Entity which would administer grant funds.* |  |
| 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: |

## 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 |
| 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 |

**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 an adjunct or honorary title or a Clinical Academic position. Add rows if necessary.

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

**Other information**

|  |  |
| --- | --- |
| Discipline/Profession |  |
| Clinician Profession  *Note: this is collected for statistical purposes only* | Allied health and health sciences  Dentistry  Medical Practitioner  Nursing & Midwifery  Non-clinician |
| 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 (Emerging Leadership Level 1)  Mid-Career (Emerging Leadership Level 2)  No postgraduate degree |
| 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 |

## 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. |

## 

## 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 applied for or received funding which overlaps 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 |  |

## Eligibility criteria

|  |  |
| --- | --- |
| The NHMRC application listed in Section 1 was assessed as being ‘fundable but not funded’ with a score equal to or above 4.5, by the NHMRC peer-review panel. | Yes |
| The applicant was deemed to be at an Emerging Leadership Level 1 or Emerging Leadership Level 2 as described in the NHMRC [Statement of Expectations](https://www.nhmrc.gov.au/funding/statements-expectations), at the time the NHMRC application was submitted to the NHMRC Investigator Grant 2024 program on 8 November 2023. | Yes |

## Activity Lead 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. 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 am eligible to, and agree that I will, re-apply to an NHMRC Investigator Grants round in 2026 as specified in the ‘Program conditions’ section of the *Guidelines and Conditions.*
5. I agree to participate in an evaluation whether the application is successful or unsuccessful
6. I have discussed the likely impact of the Activity on participating organisations, and this Activity is acceptable to them
7. I agree to obtain any research ethics and governance approvals that might be required for undertaking the funded Activity
8. 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 amount awarded
9. if I am employed by the WA public health system and the Responsible Entity is not the WA public health system entity (includes Clinical Academics where applicable), I 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. 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** |  |

## 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 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 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. 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
8. the grant will not constitute the entire financial base of the Responsible Entity, i.e. the Responsible Entity has other external sources of income
9. 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
10. 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** |  |

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