Department of Health / Raine Medical Research Foundation Clinician Research Fellowships: Round 7

Certification Form

1. Applicant

(a) I confirm that I meet the eligibility criteria specified in Section 2 of the *CRF Guidelines and Conditions*.
(b) I am not currently, and will not be during the period of the Fellowship, in receipt of paid research/academic time greater than 0.3 FTE.
(c) I agree to abide by the *CRF Guidelines and Conditions*.
(d) I declare information supplied by me on this form is complete and correct.

Full Name	
Signature	**Date**

2. Host Research Institution Representative

(a) I confirm that adequate infrastructure and research support shall be provided to the applicant for the term of the Fellowship.
(b) I am an authorised signatory for the Host Research Institution.

Full Name	
Position Title	
Institution	
Signature	**Date**

3. Research Mentor

(a) I certify that I have reviewed the application and provided feedback to the applicant.
(b) I confirm that the applicant shall receive guidance and support in relation to this project during the term of their Fellowship.

Full Name	
Position Title	
Institution	
Signature	**Date**

4. Health Service Provider Institution Line Manager (Head of Department)

(a) I confirm that the applicant is employed by the Health Service Provider institution, is undertaking clinical duties at a level not less than 0.3 FTE, and that this will continue for the duration of the Fellowship.

(b) I confirm that the applicant may be released from their post for the period of the Fellowship and that their vacated post may be adequately back-filled (if applicable).

Full Name	
Position Title	
Institution	
Email	
Signature	**Date**

5. Health Service Provider Institution Business Manager

(a) I confirm that the Budget Information and Budget Justification details contained in the Application Form are complete and correct.

(b) I understand and agree that a claim will not be made on the Department of Health or the Raine Medical Research Foundation to cover any over-expenditure of budget.

Full Name	
Position Title	
Institution	
Email	
Signature	**Date**

6. Health Service Provider Institution Representative

(a) The Health Service Provider institution endorses this application, will administer the Fellowship and will abide by the *CRF Guidelines and Conditions*.

(b) The Raine Medical Research Foundation will be notified immediately of any changes to the information provided in this application, such as the applicant leaving the Health Service Provider institution, if these changes occur prior to the Fellowship being concluded.

(c) I am an authorised signatory for the Health Service Provider institution.

Please refer to *Instructions for Health Service Provider Institution Representative Certification*.

Full Name	
Position Title	
Institution	
Signature	**Date**