Neurosurgery Network Allied Health Scholarship

APPLICATION FORM

Applicants **must** read the ACI Neurosurgery Network Allied Health Scholarship Fund Policy prior to completing this form.

Applications **must** be received by COB on the **first** Friday in May, July, August and November of a calendar year. **For 2011 only, February applications will be accepted until the end of March.**

Late, incomplete, non-current, and/or retrospective applications will not be considered.

1. A GRANT IS SOUGHT TO ASSISTANCE WITH ATTENDANCE AT:	
State/National/Australasian/International Conference:	
Short Course:	
Postgraduate Course:	
Other:	

2. APPLICANT DETAILS					
Surname:		Given Names:		DOB:	
Postal Address:					
Town:		State:		Post Code:	
Home Telephone:		Business Telephone:			
Mobile Telephone:		Facsimile:			
E-mail address:					

3. CONFERENCE / COURSE / OTHER DETAILS	
Title of Conference/Course/Other:	
Venue:	
Dates:	

4. LEVEL OF SUPPORT REQUESTED	
Conference/Course/Other Registration Fee:	
Airfare Cost (if applicable) (two quotes required):	
Accommodation (two quotes from separate venues):	
Applicants Own Contribution:	
Itemised account of expenditure for conference/course/other **(copies of all costs must be supplied)**:	
Total Amount Requested =	

5. HAVE YOU PREVIOUSLY APPLIED FOR FUNDING FROM THIS COMMITTEE?	
Yes:	No:
If yes, how much did you receive and when?	

6. HAVE YOU APPLIED FOR A GRANT FROM ANY OTHER FUNDING BODY FOR THIS CONFERENCE/COURSE/OTHER?	
Yes	No
If yes, name of funding body:	
If yes, amount and year received/applied for:	
Amounts provided may be adjusted where funding is being received from another source for the same purpose.	

7. EMPLOYMENT DETAILS	
Name of hospital/facility:	
Local Health Network:	
Position: (**include current CV** - this should be a detailed account of your academic and work history)	
Length of time with current employer:	
Length of time in current position:	

8. OBJECTIVES
Please state the objectives of attending the conference/course/other:

9. MANAGER/SUPERVISOR'S RECOMMENDATION AND APPROVAL	
Name: (print)	
Position:	Signature:
Recommended:	Not Recommended:
Reason for recommending/not recommending the application:	

10. CHECKLIST
I have: ☐ completed and signed the application form; ☐ obtained the signed manager/supervisor's recommendation; ☐ attached my Curriculum Vitae; ☐ attached a copy of my current authority to practice; ☐ attached written confirmation of attendance/registration at conference/course/other and copies of ALL costs including accommodation and airfare (where applicable, two quotes are required); OR attach conference/course/other information brochure or similar;

SYNOPSES/REPORTS

In addition to complying with other criteria stated in the scholarship policy, successful applicants are reminded of their obligation to provide the following synopses:

- Applicants receiving $500.00 or less are obliged to submit a synopsis of conference/course achievements the Allied Health Scholarship Committee;
- Applicants receiving $500.00 and 1,500.00 are obliged to submit a report of 250 - 500 words to the Allied Health Scholarship Committee;
- Applicants receiving $1,500.00 and 3,000.00 are obliged to submit a report of 500 - 1,000 words to the Allied Health Scholarship Committee;

Synopses are to be submitted within eight weeks of return/completion of attending the course/conference/other. The content needs to address the objectives of the educational opportunity, the benefits gained from attending/participating and how the participant intends to share this information with colleagues. The information provided may be used to assess the value of a program for future applicants and in producing a report for the funding body. **Persons not submitting these reports will be excluded from further funding.**

Successful applicants are required to attach copies of all receipts demonstrating expenditure of funding provided and/or documentation of completion of postgraduate course studies.

DECLARATION

I declare that the information I have provided in this application is, to the best of my knowledge, true and correct. In signing this application form I agree to abide by the criteria set out in the ACI Neurosurgical Allied Health Scholarship Policy and Guidelines, as determined by the ACI Neurosurgery Allied Health Scholarship Committee, which I have read prior to completing this application.

Signed: _____ **Date:** _____

Completed applications and inquiries to:

ACI Neurosurgery Network Manager
PO Box 699 Chatswood NSW 2057
Email: lyn.farthing@aci.health.nsw.gov.au
Mob: 0438 551 357 Ph: (02) 8844-2163