

**HEALTHWAY ABORIGINAL RESEARCH TRAINING SCHOLARSHIP APPLICATION FORM**

**SECTION A: PERSONAL DETAILS**

1. Title:Mr/Ms/Mrs/Miss/Dr:
2. Full name of applicant:
3. Are you an Aboriginal or Torres Strait Islander resident on Western Australia? Yes ☐ No
4. Home address:
5. Work address at your present institution:
6. Mobile:
7. Email:
8. Present place of employment and position:
9. Date of appointment: (day/month/year):
10. Present salary: (please state amount in Australian dollars):
11. Is your position full-time, part-time, or casual?
12. Are you applying for top-up funding? *(refer to page 5 of the guidelines)* Yes No

*If yes p*lease state:

* the award you have been offered or currently hold
* the funding body
* duration of the award
* the amount funded for *each year* of the award

1. Are you applying for a student or professional stipend?

***Complete questions 14 to 16 if you are applying for a Professional Stipend*** *(see page 5 of the guidelines)*

1. Current annual gross salary: (before deductions):

Net pay after tax (indicate frequency of payment, e.g., fortnightly, monthly):

1. Name of manager/supervisor:
2. Manager/supervisor’s telephone number: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION B: ACADEMIC RECORD OF APPLICANT**

1. Qualifications (most recent first)

|  |  |  |
| --- | --- | --- |
| **Year** | **Qualification** | **Institution** |
|  |  |  |
|  |  |  |
|  |  |  |

***Please also attach a brief curriculum vitae (maximum five pages) and a copy of your latest academic record***

1. Experience since graduation (including research and, if relevant, work experience and appointments):

|  |
| --- |
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**SECTION C: CAREER DEVELOPMENT AND STUDY PROGRAM**

1. **Career development and study program**

* Nominate the qualification to which the Scholarship will lead and the WA institution for the proposed study.

|  |
| --- |
|  |

* Provide a brief description of the course and list the course units which you will be undertaking.

**Do not exceed 150 words**

|  |
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|  |

* Detail how the Scholarship will assist with the development of your future career working in Aboriginal Health.

**Do not exceed 300 words.**

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|  |

**Section D and E are for Masters and PhDs candidates only.**

**Postgraduate Diploma and Graduate Certificate applicants move to section G.**

**SECTION D: PROPOSED RESEARCH COMPONENT**

Research Project title: Decolonising psychology in practice: Developing a holistic healing model of psychological services in Nyungar Country

|  |  |
| --- | --- |
| Proposed start date: |  |
| Proposed end date: |  |

*It will take approximately three months for Heathway to process the application, also consider the University calendar, and time required to process the ethics application and the Heathway contract.*

**Research project summary**

1. Provide a brief stand-alone summary of the research component of the training. This may include the context, aims, target group or setting, expected outcomes and benefits. Avoid the use of acronyms and technical language.

**Do not exceed 200 words.**

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1. **Study rationale and design**

* Provide a brief background on the research project, including why this research is needed.

**Do not exceed 200 words.**

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|  |

* List the objectives of the research project.

**Do not exceed 150 words.**

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| --- |
|  |

* Explain what you plan to do. Outline your research methodology.

**Do not exceed one page.**

|  |
| --- |
|  |

1. **Research outcomes and community impact**

* How will this project benefit the health of Aboriginal and Torres Strait Islander people in WA?

**Do not exceed 200 words.**

|  |
| --- |
|  |

* How do you plan to share and promote the findings of your research? In particular, how you do envision your partner agency(s) or other relevant agencies will benefit from and use your research findings?

**Do not exceed 200 words.**

|  |
| --- |
|  |

1. **Partnerships**

* Identify your partner agency(s) and the relevance of the partnership. Describe how you plan to engage with them throughout the project.

**Do not exceed 150 words.**

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|  |

* Nominate the partner agency(s) where you will spend time during the research component of the Scholarship. Indicate the approximate total hours that you plan spend at the agency.

**Do not exceed 150 words.**

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|  |

1. **Budget**

* Give a budget breakdown, including justification for the costs. Please note if additional financial support, including ‘top up’ funding, will be sought over and above the Healthway Scholarship funding, in order to complete the proposed project. Please also indicate where this additional funding will be sought.

**Do not exceed 150 words.**

|  |
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|  |

* Have you previously received or are you concurrently applying for any form of postgraduate scholarship elsewhere? If so, name the funding body to which you applied.

|  |
| --- |
|  |

1. **Project support**

* Nominate your supervisor and note their position, qualifications, major research interests and how many hours supervision will be provided to the project per week.

**Do not exceed 150 words.**

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|  |

* List the resources or other material circumstances that will be available to you to support your study and research training experience.

This may include access to data bases or data analysis programs, or access to facilities where you will undertake consultations and focus groups.

**Do not exceed 150 words.**

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**SECTION E: CLEARANCE REQUIREMENTS**

(IT IS ESSENTIAL THAT EACH PART IS ANSWERED)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Research involving humans - Please mark Y/N | Y/N |
|  |  |  |  |
|  | (i) | Does this project include research involving humans? |  |
|  |  | (If yes, complete Q31b) |  |
|  |  |  |  |
|  | (ii) | Does this project involve the administration to humans, of drugs,  chemical agents or vaccines? |  |
|  |  |  |  |
|  |  |  |  |
|  | (iii) | With regard to privacy, does this project involve the use of  personal information obtained from a Commonwealth department or agency |  |
|  |  | (including Repatriation Hospitals)? |  |
|  |  | If yes, specify the name of the department or agency |  |
|  |  |  |  |
|  |  |  |  |
|  | (iv) | If yes to any of the above, is the completed FINAL clearance form attached? |  |
|  |  | Provisional clearances will not be accepted. |  |
|  |  |  |  |

NOTE: One (1) copy of the final clearance must be forwarded to Healthway. Failure to ensure that these requirements are met will affect funding of the application if successful.

Question 27 and form on the following page must be completed when research involving humans is undertaken as part of this project.

A brief statement of the ethical issues which arise from such experimentation, and an explanation of how these issues will be addressed, must be given.

It is not sufficient to note that the “NHMRC Statement of Human Experimentation will be observed”.

1. Ethical Implications of the Project - Research Involving Humans

**HEALTHWAY Research Scholarship**

**INSTITUTIONAL APPROVAL FORM FOR**

**RESEARCH INVOLVING HUMANS**

One (1) copy of this completed approval form should be attached to the application form sent to Healthway.

APPLICANT USE .

|  |  |  |  |
| --- | --- | --- | --- |
| Chief Investigator | SURNAME | TITLE | INITIALS |
| Scientific Project Title: | | | |
|  | | | |
| Administering Institution: | | | |
|  | | | |

**ETHICS COMMITTEE USE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | **Y/N** |
| Does this project comply with provisions contained in the NHMRC’s document | | | | | |  |
| “Statement on Human Experimentation and Supplementary Notes”? | | | | | |  |
|  | | | | | |  |
| Does this project comply with the regulations governing experimentation on humans | | | | | |  |
| within your Institution and within your State or Territory? | | | | | |  |
| Comments, provisos or reservations: | | | | | | |
| Name of responsible Ethics Committee: | | | | | | |
|  | | | | | | |
| Name of Ethics Committee representative (block letters): VICKI O’DONNELL (Chairperson) | | | | | | |
| SURNAME | | | TITLE | | INITIAL | |
| Signature: | | | | Date: | | |
| Note: | (1)  (2) | This form has been produced in an effort to standardise and effectively record ethics approval for all projects submitted to Healthway. Should it prove inappropriate, an individual statement may be forwarded in lieu. As Healthway cannot provide support if ethics clearance is not provided, it is of utmost importance that this information is received.  If there is no appropriate Ethics Committee at the institution concerned, the Head of Department, or, in the case of individual researchers, the applicants themselves, should ensure that the proposal is submitted to an established Ethics Committee at a hospital or university for comment, prior to completing and signing the rest of the form as an undertaking that the provisions of the NHMRC “Statement on Human Experimentation and Supplementary Notes” will be observed. | | | | |

In addition to institution ethics clearance, applicants must obtain ethics approval through the:

Aboriginal Health Council of WA

Email:ethics@ahcwa.org

Phone: (08) 9227 1631

Website: www.ahcwa.org.au/ethics

**SECTION F: AGREEMENT TO ADMINISTER SCHOLARSHIP**

**Electronic signatures are accepted.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 28. | Certification by Administering Institution | | | | | | |
|  |  | | | | | | |
|  | I certify that should the applicant |  | | | | | be awarded a Research |
|  | Training Scholarship, this institution is willing to administer the grant on behalf of the applicant. | | | | | | |
|  |  | | | | | | |
|  | Name of certifying officer (please print) | | | | Position | | |
|  |  | | | |  | | |
|  |  | | | | | | |
|  | Name of Institution | | | | | | |
|  |  | | | | | | |
|  |  | | | | | | |
|  | Signature of certifying officer | | | | | | |
|  |  | |  |  | |  | |
|  |  | |  |  | |  | |
|  |  | |  |  | |  | |
|  |  | |  | Date: | |  | |
|  |  | | | | | | |

**SECTION G: REFEREES, HEAD OF DEPARTMENT AND SUPERVISOR**

**Please note we may contact your referees**

29. NOMINATED REFEREE (1)

|  |  |  |  |
| --- | --- | --- | --- |
|  | SURNAME | TITLE | INITIALS |

EMAIL

TELEPHONE NO:

NOMINATED REFEREE (2)

|  |  |  |  |
| --- | --- | --- | --- |
|  | SURNAME | TITLE | INITIALS |

EMAIL

TELEPHONE NO:

HEAD OF DEPARTMENT

|  |  |  |  |
| --- | --- | --- | --- |
|  | SURNAME | TITLE | INITIALS |

EMAIL

TELEPHONE NO:

NOMINATED SUPERVISOR (*For MPH or PhD applicants only*)

|  |  |  |  |
| --- | --- | --- | --- |
|  | SURNAME | TITLE | INITIALS |

EMAIL

TELEPHONE NO:

**SECTION H: PARTNER AGENCY(S) APPROVAL**

**Electronic signatures are accepted.**

30. Certification by Partnering Agency(s)

I confirm that my agency is supportive of this proposal and intend to participate in the project as outlined in this application.

PARTNER AGENCY (1)

|  |  |  |  |
| --- | --- | --- | --- |
|  | ORGANISATION | KEY CONTACT | POSITION |

EMAIL

TELEPHONE NO

SIGNATURE DATE

PARTNER AGENCY (2)

|  |  |  |  |
| --- | --- | --- | --- |
|  | ORGANISATION | KEY CONTACT | POSITION |

EMAIL

TELEPHONE NO

SIGNATURE DATE

PARTNER AGENCY (3)

|  |  |  |  |
| --- | --- | --- | --- |
|  | ORGANISATION | TITLE | INITIALS |

EMAIL

TELEPHONE NO

SIGNATURE DATE

**CONFIDENTIAL REPORT ON CANDIDATE FOR HEALTH**

**PROMOTION RESEARCH TRAINING SCHOLARSHIP**

**REPORT ON APPLICANT BY NOMINATED REFEREE**

|  |  |  |
| --- | --- | --- |
| **Name of Applicant:** | |  |
| **Institution:** |  | |
| **Project Title:** |  | |

**Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Note to applicant: Please complete the above and forward to the nominated referee with a completed copy of the application. It is recommended you agree on a date for submission of this report to Healthway.

**PART A:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | I have known the candidate for | |  | years | |
|  |  | | |  |  |
|  | I have known the candidate as | |  | | |
|  | (e.g. friend, student, colleague) | | |  |  |
|  |  | | |  |  |
|  | I have been his/her |  | | | |
|  | (e.g. tutor, dept head) | | |  |  |
|  |  | | |  |  |

**PART B**

Please provide a brief written report to assist the selection committee in evaluating the candidate’s ability. Briefly comment on the following areas:

1. Candidate’s understanding of the area of study.
2. Ability of the candidate to communicate orally and in writing.
3. Candidate’s ability to understand and evaluate the scientific literature in the field.
4. Ability of the candidate to create and explore new ideas.
5. Knowledge and ability of the candidate to use basic research techniques.
6. Ability of the candidate to collaborate and engage with the nominated partner agency(s).
7. State the candidate’s main weaknesses and whether they are likely to affect his/her ability to complete the proposed research.
8. Relevance (in your opinion) of candidate’s research/study area to Aboriginal health policy and practice in Western Australia.

(Do not exceed 3 pages)

**Referee's Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Institution |  | | |
| Signature |  | Date |  |

Once this form is completed, please email to [research@healthway.wa.gov.au](mailto:research@healthway.wa.gov.au)

**CONFIDENTIAL REPORT ON CANDIDATE FOR HEALTH**

**PROMOTION RESEARCH TRAINING SCHOLARSHIP**

**REPORT ON APPLICANT BY NOMINATED REFEREE**

|  |  |  |
| --- | --- | --- |
| **Name of Applicant:** | |  |
| **Institution:** |  | |
| **Project Title:** |  | |

**Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PART A:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | I have known the candidate for | |  | years | |
|  |  | | |  |  |
|  | I have known the candidate as | |  | | |
|  | (e.g. friend, student, colleague) | | |  |  |
|  |  | | |  |  |
|  | I have been his/her |  | | | |
|  | (e.g. tutor, dept head) | | |  |  |
|  |  | | |  |  |

**PART B**

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(Do not exceed 3 pages)

**Referee's Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Institution |  | | |
| Signature |  | Date |  |

Once this form is completed, please email to [research@healthway.wa.gov.au](mailto:research@healthway.wa.gov.au)