2027 Senior Clinician Research Fellowship - Application Form
Form Preview

Applicant Details

* indicates a required field

Applicant Name *

Metro North Payroll ID *
Please enter your Metro North employee number (ie. 00123456)

Primary Phone Number *
Must be an Australian phone number.

Alternate Phone Number *
Must be an Australian phone number.

Queensland Health Email *
Must be an email address.

Alternate Email *
Must be an email address.

Gender * ○ Female ○ Male ○ Prefer not to disclose ○ Other:

Are you of Aboriginal and/or Torres Strait Islander origin? *
○ Yes, I am of Aboriginal origin
○ Yes, I am of Torres Strait Islander origin
○ Yes, I am both Aboriginal and Torres Strait Islander origin
○ No, I am not of Aboriginal or Torres Strait Islander origin
○ Prefer not to disclose

ORCID iD
https://orcid.org/

Resumé

Note: NIH Biosketch is the required format for resumé.

Upload your resumé *
Attach a file:
A maximum of 1 file may be attached.

PDF only, four pages maximum. File Name: SCRF-XXX-2027_Resume.pdf

Current Employment

Name *

Title | First Name | Last Name

Role / Position *

Professional Stream *

Other:

Employing Metro North Facility *

Other:

https://metronorth.health.qld.gov.au/hospitals-services

Department or Unit *

Permanent Clinical FTE *

Must be a number.

Doctor of Philosophy

Degree *

○ Level 10 - Doctoral Degree (PhD)

○ Other:

Title *

Institution *

Year Awarded *

Must be a number.

Relative to Opportunity and Career Disruption

Please refer to NHMRC policy on acceptable career interruption.

Have you experienced circumstances or a career interruption that has affected your research capacity? *

○ Yes ○ No

NOTE: This information will be visible to the review panel, who are either Metro North Health staff or employees of a collaborating organisation. All panel reviewers have committed to ethical peer review principles, and have agreed to confidentiality and conflict of interest disclosure statements.

Career Interruption

Describe below the details of any career interruptions within the last ten (10) years.

List each interruption or specific circumstance as a separate line entry.

Start Date	End Date	Duration (weeks)	Reduction in FTE	Duration of Interruption (years)	Details
Must be a date.	Must be a date.	Must be a number.	Must be a number.	This number/ amount is calculated.	

Research Program Proposal

* indicates a required field

Program Title *

Brief Program Description *

Word count:
Must be no more than 250 words.
Describe how you intend to use this Fellowship.

What is the vision of your Fellowship research program? *

Word count:
Must be no more than 300 words.

Background and Rationale *

Word count:
Must be no more than 300 words.

Hypothesis *

Word count:
Must be no more than 150 words.

Aims of Program (include anticipated outcome and timeline for each of the stated aims) *

Word count:
Must be no more than 200 words.

Research Plan (must relate to aims of program) *

Word count:
Must be no more than 1000 words.

Potential significance and impact *

Word count:
Must be no more than 250 words.

Alignment with TPCH Foundation priority areas
☐ Heart ☐ Lung ☐ Mental Health ☐ Ageing ☐ Paediatrics
Select at least one

Describe how the proposal aligns with the selected priority area(s)

Word count:
Must be no more than 150 words.

Proposal Supporting Document

Upload reference list and supporting images, graphics or graphs for the research proposal(s) above. No extra content will be accepted.
Attach a file:

PDF only. References 1 page max and images, graphs or graphics 1 page max. File name: SCRF-XXX-2027_Proposal Supporting Document.pdf

Direct Research Cost Budget

TPCH Foundation will provide grant funding of $150,000 per Fellowship year to support direct research costs. Direct research costs are defined as reasonable costs directly related to the research proposal, including (without limitation), research personnel, consumables, data collection and analysis, and other research related expenses, but excluding overheads, and salary of the Fellow. The budget should be completed using this budget template and needs to be endorsed by the Metro North Office of Research Business Manager prior to submission.

Upload a detailed budget outlining how the funds will be spent on direct research costs for each year. *
Attach a file:

File name: SCRF-XXX-2027_Budget

Budget Justification *

Word count:
Must be no more than 300 words.
Provide a justification for the requested budget and a rationale as to why this funding is essential to conduct the project.

Metro North Research Project Alignment

Metro North Health Facility/Directorate *
☐ RBWH ☐ TPCH ☐ Caboolture Hospital ☐ Redcliffe Hospital ☐ STARS ☐ Kilcoy Hospital ☐ Mental Health Services ☐ Community Services ☐ Oral Health Services ☐ Public Health Unit
Other

https://metronorth.health.qld.gov.au/hospitals-services

Research Capacity, Synergy and Stakeholder Engagement

* indicates a required field

Capacity Building

How will this Fellowship advance your academic and clinical professional development? *

Word count:
Must be no more than 250 words.

How do you intend to use this Fellowship to actively engage in capacity building activities for your clinical department, across Metro North, and the wider academic and clinical community? *

Word count:
Must be no more than 250 words.

Synergy with Health Service Duties

How will you integrate this Fellowship with your clinician duties? What opportunities will it create to inform your clinical practice, advance clinical care and health service delivery within your department? *

Word count:
Must be no more than 250 words.

How will your Fellowship research program advance understanding and bridge knowledge gaps in your field, and how will it be translated and disseminated to colleagues, and the wider professional and academic community? *

Word count:
Must be no more than 250 words.

Consumer Engagement

How do you plan to incorporate consumer engagement within your research program? *

Word count:
Must be no more than 250 words.

How will your Fellowship research program translate into meaningful outcomes for the benefit of Metro North patients and the broader community? *

Word count:

Must be no more than 250 words.

Research Environment

* indicates a required field

Collaborations

How will this Fellowship and your research program be used to strengthen and build collaborations across Metro North, with our patients and people, and/or with academic or industry partners? *

Word count:
Must be no more than 250 words.

Infrastructure and Resources

Describe the infrastructure and resources that will be available to you during this Fellowship (specifying whether they are from within Metro North or external). *

Word count:
Must be no more than 250 words.

Mentor

Name *

Title | First Name | Last Name

Role / Position *

Organisation *

Phone Number *

Must be an Australian phone number.

Email *

Must be an email address.

ORCID iD

https://orcid.org/

Role and contribution *

Word count:
Must be no more than 200 words.

Letter of Support

- Upload a signed letter of support from Head/Director of Metro North Clinical Department/Unit. *Two pages max, required.*

Upload Letter of Support *
Attach a file:

PDF only. File name: SCRF-XXX-2027_Letter of Support.pdf

Certification and Signatures

* indicates a required field

Instructions

1. Download the Certification and Signatures template document from the Metro North Health Clinician Research Fellowships webpage.
2. All delegates must tick the relevant statements to indicate endorsement of the application, and sign and date their section.
3. Upload a scanned copy of the signed certification pages.

Note: Please allow sufficient time for all delegates to receive, review, sign and return the certification page to you using their usual administrative methods. Applications without all required signatures by close of applications will be deemed ineligible for consideration.

Certification Page Upload *
Attach a file:

A maximum of 1 file may be attached.
PDF only. File name: SCRF-XXX-2027_certification.pdf