CLINICAL PRACTICE POST-GRADUATE STIPEND – 2024
ENDORSEMENT FORM

Chief Investigator (Applicant)

- I certify that I meet the eligibility criteria for the grant I am applying for, including residency status.
- I agree to notify Dementia Australia Research Foundation immediately should I receive alternative funding for the project that is subject of this application, or if my eligibility against the stated criteria changes in any way.
- I certify that all the information given in this application is correct and I will accept the decision of the Dementia Australia Research Foundation as final.

Name of Applicant			
Signature		**Date**	

Supervisors and Associate Investigators

I/we certify that all the information given in this application is correct and I/we will accept the decision of the Dementia Australia Research Foundation as final.

Supervisor or Associate Investigator (if applicable)

Name of Supervisor			
Signature		**Date**	

Co-Supervisor or Associate Investigator (if applicable)

Name of Investigator			
Signature		**Date**	

Co-Supervisor or Associate Investigator (if applicable)

Name of Investigator			
Signature		**Date**	

Head of Administering Institution (or nominee)

I certify that this request satisfies the requirements of this institution and that this institution has established administrative procedures for assuring sound scientific practice in accordance with the Australian Code for the Responsible Conduct of Research. I confirm that the Chief Investigator meets all eligibility criteria, including residency status.

Name			
Position			
Department			
Institution			
Signature		**Date**	

Note: Wet ink signatures or a time/date stamped electronic signatures are required. Cursive font signatures will not be accepted.