|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| hse logo better | |  |  |  | | --- | --- | --- | | *For HSE Use Only* | | | | HSE Ref. |  |  | | DRS/15/ | | | |  | | | |

Dr. Richard Steevens’ Scholarship 2016

Applicants’ Coversheet

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| **1** | First Name: |  |  |
|  |  |  |  |
| **2** | Middle Name(s): |  |  |
|  |  |  |  |
| **3** | Last Name: |  |  |
|  |  |  |  |
| **4** | Training Body |  |  |
|  |  |  |  |
| **5** | Specialty |  |  |
|  |  |  |  |
| **6** | Sub-Specialty (if appropriate) |  |  |
|  |  |  |  |
| **7** | Title of proposed training fellowship |  |  |
|  |  |  |  |
| **8** | Location of proposed training fellowship |  |  |
|  |  |  |  |
| **9** | Name of clinical supervisor for proposed training fellowship |  |  |
|  |  |  |  |
| **10** | Period of proposed fellowship  (minimum 3 months, maximum 12 months) |  |  |
|  |  |  |  |
| **11** | Date of commencement of proposed fellowship |  |  |
|  |  |  |  |
| **12** | Current year of specialist training programme at time of application |  |  |
|  |  |  |  |
| **13** | Expected period of training still to be completed as at July 2016 before award of CCST |  |  |
|  |  |  |  |
| **14** | Is any funding already available for the proposed fellowship? (e.g. from host institution or other source) |  |  |
|  |  |  |  |
| **15** | If “yes” at Q. 14, specify the amount available |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **16** | Date of Birth (DD-MM-YYYY): |  |  |  | ▬ |  |  | ▬ |  |  |  |  |
|  |  |  |  | | | | | | | | | |
| **17** | Gender: |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **18** | Nationality: |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **19** | Country/ies of which you are a citizen: | (i) |  | | | | | | | | | |
|  |  | (ii) |  | | | | | | | | | |
|  |  | (iii) |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **20** | Postal Address: |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **21** | E-mail Address: |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **22** | Home Telephone Number (optional): |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **23** | Mobile Telephone Number (mandatory): |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **24** | Medical Council Registration Number |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **25** | Current Training Post Number |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **26** | Expected point on SpR/SR Salary scale as at July 2016 |  |  | | | | | | | | | |
|  |  |  |  | | | | | | | | | |
| **27** | Contact details for Host Institution: |  |  | | | | | | | | | |
|  | Name of proposed clinical supervisor: |  |  | | | | | | | | | |
|  | E-mail address of clinical supervisor: |  |  | | | | | | | | | |
|  | Telephone number of clinical supervisor: |  |  | | | | | | | | | |