#### WA Child Research Fund 2022/23

# **Minimum Data Form**

##### Due by: 1:00 PM (AWST) Monday 1 May 2023

* ***A completed Minimum Data Form must be submitted by the due date/time to be eligible to submit an Application Form.***
* ***This information is used to assist in preparing review panels and is not used for any selection or assessment process.***
* ***Please refer to the relevant*** [***Guidelines and Conditions***](https://ww2.health.wa.gov.au/Articles/U_Z/WA-Child-Research-Fund) ***which include application instructions.***

## Application details

|  |  |
| --- | --- |
| Activity title |  |
| Activity Lead |  |
| Responsible Entity |  |
| Amount requested (estimate)*Up to $600,000 ex GST* | $ |
| Peer Review Areas (up to 3)*Available from NHMRC* [*Sapphire Knowledge Base*](https://healthandmedicalresearch.gov.au/tutorials.html) *webpage, located under Researcher>My Applications>Peer Review Area Library* | 1.2.3. |

## Activity summary

Provide a plain language summary of the proposal, including the aims, objectives, significance and expected benefits to the WA child and adolescent health and medical sector.

*[Maximum 250 words]*

|  |
| --- |
|  |

## Activity Lead affiliations

List all the entities that the Activity Lead has affiliations with, including the Responsible Entity. Identify if an adjunct or honorary title. Add rows if necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Entity** | **Position/Title** | **Paid** | **Start date** | **End date** |
|  |  | Y/N | dd/mm/yy | dd/mm/yy |
|  |  | Y/N | dd/mm/yy | dd/mm/yy |
|  |  | Y/N | dd/mm/yy | dd/mm/yy |

## Team members

Provide details of all team members involved in the Activity. Add rows if necessary.

If a team member is affiliated with more than one entity or has more than one position/title at one entity, complete a new line for each of these.

|  |  |  |  |
| --- | --- | --- | --- |
| **Team member** | **Entity** | **Position/Title** | **Paid** |
|  |  |  | Y/N |
|  |  |  | Y/N |
|  |  |  | Y/N |

## Assessors not to be approached

Please provide the name of any person not to be approached to assess the application, if applicable. This information will only be available to the Office of Medical Research and Innovation.

|  |  |
| --- | --- |
| **Name** | **Entity** |
|  |  |
|  |  |
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on request for a person with a disability.**

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