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**Linsell Richards Education Foundation Application for Funds**

The Linsell Richards Education Foundation (the Foundation) is a fund set up to commemorate the life of Linsell Richards, a former Member of the Society who served as an Examiner in Otolaryngology for The College, as a Member of the RACS NZ Committee, as NZ Director of Training in Otolaryngology, and as Society President.  After his untimely death on 21 June 1986, while still President of the Society, a fund was collected in his memory, in order to continue and develop the academic pursuits in the Specialty. This was achieved by a special collection undertaken for that purpose, which fund remains separate from subscriptions and any administrative funds of the Society.

Applications to the LREF are considered 6-monthly by a committee that consists of members of the New Zealand Society of Otolaryngology Head and Neck Surgery (NZSOHNS) council.

The objects of the Foundation are to advance knowledge in the Specialty, and for educational and research purposes, and the funds of the Foundation shall be applied to those objects and purposes. Decisions to award grants should include due consideration of the benefits to the membership as a whole.

If successful, applicants will be contacted 6-monthly for progress updates which are expected by email after request.

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| Surname: |  | First Name(s): |  |

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| Address: |  |

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| Telephone Numbers: Day: |  | Night: |  |

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| Email Address: |  |

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| Employment Status/Stage of Training: |  |  |

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| --- | --- |
| Title of Proposed Project: |  |
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| Name of Supervisor(s) (if applicable): |  |

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| Institution: |  |  |

Amount of funds applied for NZ$ ………………………………………

 Has ethical (ERMA, Animal Ethics or Human Ethics as appropriate) approval been obtained? (If yes, supply evidence):

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| YES |  |  | NO |  |  | Not Required |  |

Details of research scholarships you have previously received:

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Outline of proposed use of funds (limit to space provided):

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Proposed budget:

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 Signature of Applicant: ................................................................ Date: / /

 Name of Clinical Director: ................................................................

 Signature of Clinical Director: ................................................................ Date: / /