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#### The Royal College of Radiologists

# Application for the

## DR KAROL SICHER CANCER RESEARCH FELLOWSHIP 2024

### *Please complete the form electronically and submit by email. The form has been set up so that a tab return will take the applicant to the next amendable field. The fields will expand to fit the text that is typed, but PLEASE NOTE that the completed form should not exceed 10 pages.*

### Details of Applicant

|  |  |
| --- | --- |
| ***Surname*** | |
| ***Other Names (in full)*** | |
| ***Correspondence Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |
| ***Current Post*** | ***Name of Training Scheme or Hospital*** |
| ***Please list any previous funding granted in the last five years*** | |
| ***Relevant publications (list 5)*** | |

***For inexperienced researchers, the first co-applicant listed should be a mentor. Please indicate this below.***

### Details of Co-applicant (1)

|  |  |
| --- | --- |
| ***Surname*** | |
| ***Other Names (in full)*** | |
| ***Correspondence Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |
| ***Current Post*** | ***Name of Training Scheme or Hospital*** |
| ***Please list any previous funding granted in the last five years*** | |
| ***Relevant publications (list 5)*** | |
| ***Please tick box if this individual will act as mentor*** | |

### Details of Co-applicant (2)

|  |  |
| --- | --- |
| ***Surname*** | |
| ***Other Names (in full)*** | |
| ***Correspondence Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |
| ***Current Post*** | ***Name of Training Scheme or Hospital*** |
| ***Please list any previous funding granted in the last five years*** | |
| ***Relevant publications (list 5)*** | |

### Details of Co-applicant (3)

|  |  |
| --- | --- |
| ***Surname*** | |
| ***Other Names (in full)*** | |
| ***Correspondence Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |
| ***Current Post*** | ***Name of Training Scheme or Hospital*** |
| ***Please list any previous funding granted in the last five years*** | |
| ***Relevant publications (list 5)*** | |

### Details of Co-applicant (4)

|  |  |
| --- | --- |
| ***Surname*** | |
| ***Other Names (in full)*** | |
| ***Correspondence Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |
| ***Current Post*** | ***Name of Training Scheme or Hospital*** |
| ***Please list any previous funding granted in the last five years*** | |
| ***Relevant publications (list 5)*** | |

### Details of Co-applicant (5)

|  |  |
| --- | --- |
| ***Surname*** | |
| ***Other Names (in full)*** | |
| ***Correspondence Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |
| ***Current Post*** | ***Name of Training Scheme or Hospital*** |
| ***Please list any previous funding granted in the last five years*** | |
| ***Relevant publications (list 5)*** | |

### Project Summary

|  |
| --- |
| *Project Title* |
| ***Lay summary (max 300 words)*** |
| ***Proposed duration and dates of project*** |
| ***Where will the project be carried out?*** |
| ***Likely contribution of project to patient outcomes*** |

##### 

##### Details of Funding

|  |
| --- |
| ***Total Amount of Funding Requested*** |
| ***Detailed Justification of the Financial Support Requested*** |
| ***Details of Other Funding Requested or Obtained*** |

##### Details of Project

|  |
| --- |
| ***Background (max 400 words)*** |
| ***Methodology and techniques of study (max 1500 words)*** |
| ***Supervision Arrangements (max 250 words)*** |
| ***Experience of Supervising Research Team (max 250 words)*** |
| **Details of Timescale/project breakdown** |

**Details of Referees**

**Both of whom should be external consultant clinical radiologists or clinical oncologists (as relevant). One of the referees should be the head of the department in which the applicant is working. The other should be unconnected to the project and based at a different institution to the applicant.**

|  |  |
| --- | --- |
| ***First Referee’s Full Name and Job Title*** | |
| ***Hospital Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |

|  |  |
| --- | --- |
| ***Second Referee’s Full Name and Job Title*** | |
| ***Hospital Address*** | |
| ***Daytime Telephone Number*** | ***E-mail address*** |

##### Applicant’s Declaration

I declare that the information given on this form and in its enclosures is complete and correct. If the Dr Karol Sicher Cancer Research Fellowship is awarded to me, I will use the money for the stated purpose and abide by the conditions of the award. If I have any difficulty in completing the project according to the timetable, I will inform the College. All research should be conducted to the highest ethical standards and be subject to the permission and scrutiny of the local medical ethics committee and the institution(s) where the research will be conducted.

I agree with this statement (check box)

**Date:**

##### Documentation to be enclosed with Application Form

Curriculum vitae (maximum 2 pages)

Letter(s) of support from the project supervisor(s) at the centre(s) at which the project is to be undertaken.

*Please email completed form and electronic copies of all accompanying documentation to:*

[research@rcr.ac.uk](mailto:research@rcr.ac.uk)

***to arrive no later than 5pm on Friday 17 November 2023***