

**The Lucian Leape Patient Safety Fellowship (Leape Fellowship)**

Application Form

Third Party Nominations

**Application Form for Nominating Third Parties**

**Your Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** | **First name(s)** | | **Last name** |
|  |  | |  |
| **Contact details *(For telephone numbers please provide country and city codes)*** | | | |
| **Postal address:** | | | **Telephone:**  **Email:** |
| **Current Occupation:** | | **Are You an ISQua Member? Yes  No**  If Yes, Membership Number: | |
| **Nominating Statement** | | | |
| **This statement will be a key deciding factor in the shortlisting of candidates. Your statement should state the reasons for your nomination and be no more than 500 words. Please indicate the following;**  *- How would your nominee benefit from the Fellowship on both professional and personal levels*  *- How completing the Fellowship will benefit your nominee’s local region*  *- Your nominee’s ability and opportunity to influence policy in their country of origin* | | | |
|  | | | |

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| --- |
| **In no more than 200 words, please describe what you envisage your nominee’s future role to be** |
|  |

**Nominee Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** | **First name(s)** | | **Last name** |
|  |  | |  |
| **Contact details *(For telephone numbers please provide country and city codes)*** | | | |
| **Postal address:** | | | **Telephone:** |
| **Email:** |
| **Current Occupation:** | | **Is the nominee an ISQua Member? Yes  No** | |

The following documents must be provided by the nominee and included with this application form:

|  |  |  |
| --- | --- | --- |
| **Document** | **Mandatory/Desirable** | **✓/🗶** |
| An up to date CV outlining the candidate’s education and career to date | *MANDATORY* |  |
| 2 referees to be current or recent employers (please include email addresses) | *MANDATORY* |  |
| Letter of support from candidate’s employer, allowing them to retain employment whilst taking part in the Fellowship. | *MANDATORY* |  |
| Commitment from your home institution to provide you with a role in the organisation’s patient safety programme on completion of programme. | *MANDATORY* |  |
| The completed application form | *MANDATORY* |  |

|  |  |
| --- | --- |
| Referee 1 | |
| Name |  |
| Occupation |  |
| Relationship to Candidate |  |
| Contact Details |  |
| Email Address |  |
| If applicable, ISQua Membership Number: |  |
| Referee 2 | |
| Name |  |
| Occupation |  |
| Relationship to Candidate |  |
| Contact Details |  |
| Email Address |  |
| If applicable, ISQua Membership Number: |  |

**Please complete this application form and submit all the required**

**documentation by email to Caitríona Curran (**[**ccurran@isqua.org**](mailto:ccurran@isqua.org)**) no later than February 15th 2019**

If successful, ISQua have my permission to contact my referees

I confirm that the information on this application is true and correct to the best of my knowledge

**Signed (Third-Party):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_\_\_

**Signed (Nominee):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_\_\_