

Private Bag 1, Houghton, 2041, Republic of South Africa
Tel: +27 (11) 484-5288
Fax: +27 (11) 642-5718 / 086 683 0933
E-mail: secretary@sada.co.za



APPLICATION FORM FOR RESEARCH GRANT

- Applicants are requested to acquaint themselves with the general principles underlying the granting of research funds.
- Completed application forms and any supporting annexures must be submitted via email in a PDF format to secretary@sada.co.za before advertised closing date.

LATE APPLICATIONS WILL NOT BE CONSIDERED.

If space is insufficient, please indicate on form and attach a schedule.

Details

1 Full name of applicant: _____

2 Postal address: _____

3 Physical address: _____

4,1 Work tel: _____

4,2 Home tel: _____

4,3 Cell: _____

4,4 E-mail address: _____

5 Date of Birth: _____

Are you a member of the SA Dental Association?

Yes

No

Category of SADA membership: _____

When did you become a member of SADA? _____

6 Tertiary Education

Detail each degree/diploma:

University/Institution	Degree/Diploma	Year

Details of any academic or other distinctions:

Are you presently registered as a candidate for any degree or diploma?

Yes No

Please detail:

7,1 Present Appointment:

Institution:

Post:

For how long have you held that post:

Was your post:

Part-time Full-time

7,2 Previous Appointments / Details of Private Practice / Occupation since graduation (Give dates, please) :

8 Detail any Teaching or Research Experience not included in 7 above:

9 Publications

Yes No

9,1 Submit as an annexure details of work published during the previous five years:

[a] as full scientific articles in refereed Journals

[b] in abstract form

[c] as books or chapters in books

[d] other

9,2

Submit as an annexure a list of papers you have presented at scientific meetings during the previous five years.

10 Research Project

Kindly attach a short but clear protocol of your proposed programme of research (no more than three typed A4 sheets) under the following headings:

Introduction

Aim of study

Methods and Materials

Statistical Analysis

Estimated cost of project and budget (include running costs, purchase of apparatus, research assistant, travel and subsistence.) See Rules 5, 6 and 7.

10.1 Where will work be carried out? _____

10.2 How long do you expect it to take? _____

10.3 Is the project for a degree/diploma? _____

10.4 If Yes, which degree/diploma? _____

Which Institution? _____

10.5 Name and status of supervisor (if applicable): _____

10.6 Is the project accepted by your Institution's Ethical/Research Committee?: Yes No

Registration number: _____

10.6.1 Registration:

10.6.2 A letter from Institution:

11 Have you applied to other sources for financial assistance to help implement your programme? (Please detail. If the outcomes of your applications are not yet known, please inform the Dental Association as soon as a decision has reached you.)

12 If you propose to follow your programme outside South Africa, state reasons why you cannot do a similar programme within South Africa. A supporting statement from you Head of Department should be attached, if applicable.

13 References

Indicate below the names and addresses of two referees who should be requested to sign this application to signify their willingness to supply the confidential reference prior to the advertised closing date.

References must be submitted to: The Chairperson
 DDF Trust
 Private Bag 1
 Houghton
 2041

References must be marked: Private and Confidential

Referees should be requested to comment on the ability of the applicant and the merit of the project.

13,1 Name: _____
Address: _____

Signature: _____

13,2 Name: _____
Address: _____

Signature: _____

14 Declaration by Applicant

I certify that these statements are correct, and that if awarded a research grant, I shall observe the conditions and regulations stipulated by the Trustees of the Dentistry Development Foundation Trust of the South African Dental Association. Further, I undertake that I will live and work in the Republic of South Africa for a minimum of two years after my receiving the grant or to return the monies to the Association.

Applicant: _____
(Signature)

Date: _____

In witness hereof, I _____ hereby append my signature.

Witness: _____
(Signature)

Date: _____

15 Recommendation

To be completed by the University or Institution to which the Applicant is attached, or, by the Committee of the Branch of the SA Dental Association of which the applicant is a member.

This is to certify that: _____
Name of University, Institution or Branch of SADA

Recommends this programme of study and supports this application.

Remarks (if any): _____

Signature and Status of Representative of University/Institution Date



OFFICIAL STAMP OF UNIVERSITY, INSTITUTION OR BRANCH OF SADA