**Scholarship Program Recommendation Form**

The Board of Directors of the Australian Academy of Cerebral Palsy and Developmental Medicine (AusACPDM) is committed to making the Conference accessible to persons from resource poor communities or workplaces, or where attendance at the conference would not be possible without additional funding support.

Therefore, the AusACPDM is offering Scholarships for Australasian (Australia/NZ/Pacifica) and International attendees. As a hybrid event, and because of ongoing uncertainty regarding travel across Australia’s borders due to COVID-19, scholarships for International attendees will be for virtual attendance only. We encourage our prospective Australasian applicants to consider how they intend on participating in the conference and so will be asking the applicant to commit to choosing the type of registration they are wanting to apply for from the following options:

|  |  |
| --- | --- |
| Virtual attendance: | In person attendance: |
| Virtual registration | In person registration |
| Low resource virtual registration | Low resource in person registration |
| Low resource group virtual registration | Student in person registration |
| Student virtual registration |  |

Applicants are asked to upload this recommendation form as completed by their employer or student body, which includes but is not limited to the applicant’s area of work in childhood disability, capacity to speak and understand English, how the applicant will benefit from the conference and how the applicant will disseminate the knowledge on return home.

Please upload this form as instructed on the Scholarship Application Submission webpage by 30th April 2021.

*SECTION 1 - TO BE COMPLETED BY APPLICANT*

|  |  |
| --- | --- |
| **NAME OF APPLICANT** |  |
| **APPLICANT’S ROLE & ORGANISATION** |  |
| **SUBMITTED ABSTRACT TITLE/S, if applicable** |  |
| **PAST SCHOLARSHIP RECIPIENT** | Yes No Year/s received |

*SECTION 2 – TO BE COMPLETED BY AN EMPLOYER, SUPERVISOR OR ACADEMIC INSTRUCTOR WHO HAS WORKED WITH THE APPLICANT*

|  |  |  |
| --- | --- | --- |
| **NAME** |  | |
| **TITLE & POSITION** |  | |
| **INSTITUTION** |  | |
| **EMAIL ADDRESS** |  | |
| **SIGNATURE** |  | **DATE** |

1. In what capacity and how long have you known the applicant?

|  |
| --- |
|  |

Student Supervisor

Trainee Supervisor

Clinical Colleague

Academic Colleague

Other  Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. In what way would attending this meeting contribute to the applicant’s academic or professional development?

3. How will the applicant disseminate knowledge gained at the conference to their organisation or network?

4. How would you rate the applicant in the following areas? If you are unable to evaluate an area please leave it blank.

Excellent Very Good Average Below Average

Clinical knowledge

Academic knowledge

Leadership

Initiative

Seriousness of purpose

Adaptability

Maturity

Teaching ability

Research generation

5. Please rate the applicant’s present English language capability as you know it.

Superior Good Fair Basic

Reading

Writing

Comprehension

Speaking

6. Additional comments:

|  |
| --- |
|  |