

BRITISH MEDICAL AND DENTAL STUDENTS' TRUST

Registered Charity No. 313511

TRAVEL SCHOLARSHIPS APPLICATION FORM

Closing dates:

31st January for electives from April to September

31st July for electives from October to March

When you have completed this form please ask your Tutor/Supervisor or other authorised person if he or she will provide the information requested under Section D, and then to forward the application direct to the Secretary of the Trust.

SECTION A: Personal Details

1. Surname: (Mr/Mrs/Miss)

2. Forename(s):

3. Medical/Dental School:
(delete as applicable)

4. Expected year of Qualification:

5. Degrees held *(if any)*:

6. Address for Correspondence:

OFFICE USE ONLY

(D)

Protocol Ref by

Partners

.....

SECTION B: Details of Proposed Visit

7. Dates of visit:
8. Are you travelling as an individual or in a group?
(Give details including names)

9. Country/Countries to be visited:

10. Hospitals and Centres to be visited:

Department:

Role:

Associated work in community:

Medical/Dental project *(Protocol **must** be enclosed with application)*

Proposed medical/dental courses or visits to other places of medical/dental interest:

11. Have your arrangements been confirmed? If so, by whom?
*(Photocopy of confirmation letter or e-mail **must** be available for the Trustees meeting.)*

12. If going to an organised Clinical Conference, state:

Title:

Place:

Dates:

Titles of any papers to be presented:

(Please enclose photocopy of programme)

SECTION C: Cost

13. Details of estimated costs:

Total

Travel:

Accommodation:

Extra (*Give details*):

£

14. Will you receive payment for your work abroad?

15. If so, how much?

16. Have you received, or had definite information that you will receive, a grant from any other source? (*Give details*)

17. What other attempts have you made to raise money?

DECLARATION

I hereby declare, that to the best of my knowledge, the above information is correct.
I understand that the decision of the Trustees is final and I agree to accept the same.
I have read and agree to the conditions.

Signed:

Date:

SECTION D

This Section is to be completed by your Tutor/Supervisor or other authorised person at your place of study.

18. How long has the applicant been known to you?

19. From your personal knowledge of the applicant, please give a brief report on his/her character and ability to complete the project.

20. Is there anything more you would like to add in support of this application?

Signature:

Position:

Date:

University or College Stamp

When you have completed and signed this report, please return it to:
The Secretary, British Medical and Dental Students' Trust,
Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA.
Telephone: 0141 221 5858