

**FINAL GRANT ACCOUNTABILITY REPORT: ESPE CLINICAL FELLOWSHIP**

***[To be completed in full towards the end of the fellowship or within 4 weeks of fellowship completion and sent along with the receipts/bills and fellowship report (see separate form on the website) to ESPE Team (espe@mci-group.com) – the final 20% payment will be made ONLY after receipt all these forms on time]***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **FELLOW DETAILS:** | | | |
|  | Name: |  | | | |
| Address: |  | | | |
| Postal Code: |  | City: |  | |
| Telephone: |  | | | |
| E-mail: |  | | | |

|  |  |  |
| --- | --- | --- |
|  | **DATE OF ACCOUNTABILITY REPORT** | |
|  | Date: |  |

|  |  |  |
| --- | --- | --- |
|  | **INITIAL GRANT PAID INTO BANK ACCOUNT** | |
|  | IBAN: |  |
| Date: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **PERIOD OF FELLOWSHIP & PAYMENT MADE SO FAR:** | | | | |
|  | 3 months (dates): |  | Amount paid €: |  |
| 6 months (dates): |  | Amount paid €: |  |

|  |  |  |
| --- | --- | --- |
|  | **NAME OF CENTRE WHERE FELLOWSHIP TOOK PLACE** | |
|  | Name of Centre: |  |
| City: |  |
| Country: |  |
| Host name |  |

**EXPENDITURE DETAILS**

**Please complete the following breakdown of ALL expenditure, making sure to attach copies of every receipt (apart from pocket money expenses). Please number each receipt, ensuring that the number is in the file name and record below the amount paid in the currency used (if not Euros) and then convert to Euros. The amount paid must be clearly visible on the receipt copy and highlighted if necessary. Please provide a brief description of what the receipt is for in the “Item” column (e.g. Return Flight Tbilisi – Paris). Please add more rows to the bottom of the table if required.**

|  |  |  |
| --- | --- | --- |
| **Item** | **Amount in currency on receipt** | **Amount in Euros** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  | **TOTAL:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | ***[Please label the bills accordingly with the expense name eg., ‘flight receipt’, ‘insurance bill’ etc., before attaching to the email]***  **HAVE YOU FULLY SPENT THE FUNDS GRANTED?** | | | |
|  | Yes: |  | \*No: |  |
| *If NO: Transfer of the remaining amount to the ESPE Bank account is requested, details included below.* | | | |
| European Society for Paediatric Endocrinology (ESPE)  Bank: ING Belgium SA/NV  Bank address: ING Belgium, Rue du Trone 14-16, 1000 Bruxelles  Bank account: 310-1773908-58  IBAN: BE95 3101 7739 0858  SWIFT: BBRUBEBB  Reference: Clinical Fellowship/ APPLICANT NAME | | | |

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| **9.** | **WHAT WERE THE KEY OUTCOMES FOR YOU AS A RESULT OF THE CLINICAL FELLOWSHIP GRANT:** |
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| --- | --- | --- |
| **DECLARATION** | | |
| ***Please note: this form should be signed by the fellow and the Host Supervisor*** | | |
| **10.** | **FELLOW** | |
|  | Full name: |  |
| Signature: |  |
| Date: |  |

|  |  |  |
| --- | --- | --- |
| **11.** | **HOST/SUPERVISOR** | |
|  | Full name: |  |
| Signature: |  |
| Date: |  |

|  |  |
| --- | --- |
| **15.** | **REMARKS BY THE HOST ABOUT THE FELLOW AND THE FELLOWSHIP PROGRAM:** |
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