**CLINICAL FELLOWSHIP (INITIAL) GRANT REQUEST FORM**

***(Fellows should complete this ONLY after reaching the host centre and return the form signed by the supervisor to ESPE Team by email (espe@mci-group.com) after which the initial 80% of the grant will be made to the fellow’s bank account)***

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| --- |
| **FELLOW DETAILS** |
| **First Name** |  |
| **Last Name** |  |
| **Address** |  |
| **Country** |  | **Postal code** |  |
| **Telephone** |  |
| **Email** |  |

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| **HOST CENTRE DETAILS** |
| **Name**  |  |
| **Address** |  |
| **Country** |  | **Postal code** |  |
| **Telephone** |  |
| **Email** |  |
| **Period** | **3 months** |  | **6 months** |  |

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| **BANK DETAILS** |
| **Bank name** |  |
| **Bank address** |  |
| **SWIFT/BIC code** |  | **IBAN Number** |  |
| **Name of account holder** |  |
| **Address of account holder** |  |
|  |  |

**BUDGET REQUEST**

**Please complete the below in discussion with your supervisor in the host center only once you have started your fellowship. Authorisation signature of host supervisor is required for the funds to be transferred. You will not be permitted any additional funds on top of that which was awarded in your grant acceptance letter. In the initial claim you will receive 80% of the total claimed below. Please note that copies of receipts are not required for the initial claim so please ensure that the projected costs stated below are as accurate as possible.**

|  |  |  |
| --- | --- | --- |
|  | *Expenditure*  *Monthly* | *Total for* **3 months** **6 months** |
| Travel costs [based on 1 return ticket, most economical transport]  |  |  |
| Visa and related costs  |  |  |
| Health Insurance (in the country of destination)  |  |  |
| Accommodation (housing on campus or outside) – please find the most economical accommodation as much as possible – expenses for family members will not be paid |  |  |
| Pocket money (for food, local transportation and other expenses –please see financial guidelines for monthly limits) |  |  |
| Institutional fees or fellowship arranging fees in the host centre (if any) |  |  |
| Other costs |  |  |
|   |  |  |
|  |  |  |
| TOTAL  |  |  |

***Host Supervisor’s name & Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Host Supervisor’s Signature & Date­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***