**Medical Student Audit and QIP Prize Submission form**

Name

Medical School

Year of medical school training

Email address

Telephone number

Name of audit supervisor or tutor

Email address for supervisor or tutor

Title of audit/service evaluation/quality improvement project

Roles of all members of the project (please tick the most appropriate boxes):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Project lead | Project design | Data collection/analysis | Report writing |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

By submitting this project, I confirm that:

1. Appropriate ethical principles have been followed including data protection and confidentiality
2. I am responsible for this work and am able to vouch for the project’s authenticity, accuracy and integrity

Signed: Date: