Berlin Institute of Health at Charité – Universitätsmedizin Berlin

DIGITAL HEALTH ACCELERATOR PROGRAM 2024

Protected Time Form:
Application for Protected Time – Team member 1

Project Title:

Confirmation of Financing as Part of the Funding Covered by the BIH Digital Health Accelerator Program Stage 1 (1 February 2024 to 31 July 2024)

I hereby confirm as director of the clinic / institute

_____

at Charité – Universitätsmedizin Berlin / Berlin Institute of Health at Charité, that (first name, last name) _____ receives our fullest support with the implementation of the proposed project.

We are ensuring her / him /them up to **50 percent** exemption of clinical/ research tasks for the BIH Digital Health Accelerator Program during the funding period.

After conclusion of the funding and concerning the labor law, the clinic/ research institute will enable her / him / them continued employment in the previous position.

I agree to have knowledge of the fact that the BIH Digital Health Accelerator Program cannot continue the funding of her / him/ them if these requirements are not met.

Date	**Name of Director of Clinic / Institute**	**Signature**

Berlin Institute of Health at Charité – Universitätsmedizin Berlin

DIGITAL HEALTH ACCELERATOR PROGRAM 2024

Protected Time Form:
Application for Protected Time – Team member 2

Project Title:

Confirmation of Financing as Part of the Funding Covered by the BIH Digital Health Accelerator Program Stage 1 (1 February 2024 to 31 July 2024)

I hereby confirm as director of the clinic / institute

_____

at Charité – Universitätsmedizin Berlin / Berlin Institute of Health at Charité, that (first name, last name) _____ receives our fullest support with the implementation of the proposed project.

We are ensuring her / him /them up to **30 percent** exemption of clinical/ research tasks for the BIH Digital Health Accelerator Program during the funding period.

After conclusion of the funding and concerning the labor law, the clinic/ research institute will enable her / him / them continued employment in the previous position.

I agree to have knowledge of the fact that the BIH Digital Health Accelerator Program cannot continue the funding of her / him/ them if these requirements are not met.

Date	**Name of Director of Clinic / Institute**	**Signature**