HEALTH SCIENCE PROFESSIONALS

HSPBA Professional Development Fund

Application Form

- For education/training commenced between September 1, 2018 and August 31, 2019
- Application Form to be submitted ASAP and no later than July 1, 2019

Applicant Details

Name: _____

Worksite: _____

Employer: ☐ NHA ☐ IHA ☐ FHA ☐ VCH

☐ VIHA ☐ PHSA ☐ PHC

☐ Lower Mainland Consolidated Service, specifically: Medical Imaging

☐ Other (describe): _____

Discipline: _____

(e.g. Physiotherapist, Psychologist)

Job title: _____

Department/Program/Team name: _____

Employment status: ☐ Regular Full-time or Part-time ☐ Casual

☐ Temporary - temporary term end date: _____

Contact Information

Home address: _____

(street address, city, postal code)

Daytime home/cell number: _____

Phone number at work: _____

Personal email address: _____

Description of Education/Training for which Funding Support is Requested

Identify the type(s) of professional development event/instruction:

☐ Workshop ☐ Course ☐ Seminar ☐ Program

☐ Conference ☐ Clinical Placement ☐ Distance Learning

☐ Other – describe: _____

Name of education/training provider/institute: _____

Start date for requested event/instruction: _____

Registration deadline, if applicable: _____

Completion date for requested event/instruction: _____

☐ Yes, I have attached the education provider's outline of, or link to, the requested event/instruction. The web link is: _____

☐ No, I have not attached an outline or link, because neither is available. Instead, I describe the event's/instruction's content as serving the following professional development purpose:

Details of Application Category

My application, if approved, would serve to (please check all applicable categories):

☐ Help to retrain me for a health science profession **for which there is a shortage**. Examples include:

☐ Physiotherapist ☐ Occupational Therapist ☐ Sonographer

☐ Perfusionist ☐ Other: please specify _____

☐ **Or** my application, if approved, would retrain me for a health science profession **that may experience shortages and will contribute to the inter-professional team** in Ministry of Health priority areas such as Primary Care Services, Adults with Complex Medical Conditions and/or Frailty, Surgical and Diagnostic Services, Mental Health and Substance Use Services, Anesthesia Services, Palliative Care, and Indigenous Health.

Examples include:

☐ Psychologist	☐ Psychosocial Rehabilitation	☐ Speech Language Pathologist
☐ Social Worker	☐ Trained Peer Support	☐ Aboriginal Patient Liaison/Navigator
☐ MRI Technologist	☐ Anesthesia Assistant	☐ Cross-Cultural Liaison
☐ Pharmacist	☐ Dental Hygienist	☐ Recreation Therapist
☐ Nutritionist	☐ Dietitian	☐ Public Health Expert
☐ Counsellor	☐ Clinical Counsellor	☐ Vocational Counsellor
☐ Music Therapist	☐ Art Therapist	☐ Other: please specify _____

☐ Assist me in meeting my **ongoing requirements** for professional development.

☐ Enhance my professional development opportunities as a health science professional working specifically in a **rural or remote area**.

Please state the name of the community in which your rural or remote worksite is located, as well as the name(s) of any other community (including First Nations communities) to which you travel to provide service:

Indicate below how your proposed training/professional development will prepare you to contribute to one or more of the following Ministry priority areas (check all relevant areas):

☐ Primary Care Services. Describe: _____

☐ Adults with Complex Medical Conditions and/or Frailty. Describe:

☐ Surgical and Diagnostic Services. Describe:

☐ Mental Health and Substance Use Services. Describe:

☐ Anesthesia Services. Describe:

☐ Palliative Care. Describe:

☐ Indigenous Health. Describe:

Part A: Cost of Education/Training for which Funding Support is Requested

Cost of tuition fees $ _____ ☐ Not applicable

Cost of registration fees $ _____ ☐ Not applicable

Cost of required books/materials $ _____ ☐ Not applicable

Cost of other reasonable
education/training-related expenses $_____ ☐ Not applicable

Describe:

Total dollar amount requested for Part A costs: $ 0.00

Part B: *Cost of Travel and Accommodation Within B.C. to Access Education/Training

*Cost of travel: ☐ Not applicable; ☐ Applicable – describe:_____

*Cost of accommodation: ☐ Not applicable; ☐ Applicable – describe:_____

*These costs will be considered for funding support *if you must travel or temporarily relocate* within B.C. to attend education/training or related clinical placement. They are in addition to the tuition, registration, cost of required books/materials, and other reasonable education/training-related expenses.

Total dollar amount requested for Part B costs: $ _____

TOTAL DOLLAR AMOUNT REQUESTED FOR BOTH PART A and B COSTS: $ 0.00

Funding From Any Other Source

I have received or anticipate receiving some funding support for this same event/instruction from another source: ☐ No ☐ Yes. If yes, please provide the amount and describe the funding support(s):

Signature and How to Submit Your Application

Applications will be considered for funding support **in the order they are received**, while funds last.

☐ I confirm that all information provided in this application is true and correct to the best of my knowledge.

Please select one of the following two methods to submit your completed application to HSA. Method One offers administrative efficiencies that will speed up processing of an application.

Method One

- **Instructions:**
  - Download the application form
  - Complete the application form electronically
  - Save the completed form in .PDF format *only*
  - Attach and email the saved form to: PDFund@hsabc.org

Method Two

- **Instructions:**
  - Download the application form
  - Complete the application form electronically
  - Print the completed form and mail it to:

    Health Sciences Association of B.C.
    180 East Columbia Street
    New Westminster, BC V3L 0G7
    Attention: Professional Development Fund

If you print the completed form and mail it to the HSA office, your signature and date are required:

_____ _____

Signature Date signed

Privacy Statement

The HSA is committed to using the personal information we collect in accordance with applicable privacy legislation. By completing this form you are consenting to have HSA use the submitted information for the purposes of conducting our representational duties as a union, and in providing services to our members. For further information please contact the HSA Privacy Officer at privacy@hsabc.org