



Application Form

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

Applicant Details

I have read the **FAQ (Frequently Asked Questions)** document, as posted at:
<https://hsabc.org/member-benefits/professional-development-and-member-education>

Name: _____

Worksite: _____

Employer: NHA IHA FHA VCH

VIHA PHSA PHC

Lower Mainland Consolidated Service, specifically: _____

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: _____

Note: Your decision letter will be sent to your 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 course(s), workshop, or instruction event:

Name of education/training provider/institute:

Course Delivery (i.e. in-person, or online, or a combination):

Location of course: _____
City and Province; City and USA State; or City & other international country

Start date(s) for event(s)/course(s)/instruction:

Completion date(s) for requested event(s)/course(s)/instruction:

Registration deadline, if applicable: _____

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

Describe the event's/instruction's content as serving the following professional development purpose:

Other notes:

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

If you are applying for funding support for the cost of education *outside Canada*, i.e. within the U.S.A. or other international country, please provide your rationale, eg. describe how the education/training is highly specialized and not available within Canada:

Cost of tuition fees

Not applicable

Description:

Amount \$

Cost of registration fees

Not applicable

Description:

Amount \$

Cost of exam fees

Not applicable

Description:

Amount \$

Cost of required books/materials

Not applicable

Description:

Amount \$

Cost of other reasonable education/training-related expenses

Not applicable

Description:

Amount \$

Notes :

Total dollar amount requested for Part A costs: \$ _____

Part B: *Cost of Travel and Accommodation Within Canada or the USA to Access Education/Training

If you are applying for funding support for the cost of travel and accommodation *outside Canada*, i.e. within the U.S.A., please provide your rationale, eg. describe how the education/training is highly specialized and not available within Canada:

***Cost of travel – within Canada or the USA only:** Not applicable; Applicable

Economy Airfare: From _____ to _____ \$

Ferry/reservation: From _____ to _____ \$

Parking: _____ # of days x _____ rate per day = \$

Transit: _____ # of days x _____ rate per day = \$

Mileage (home to/from education): _____ km @ \$0.58 per km = \$

Other: _____ \$

Notes:

***Cost of accommodation – within Canada or the USA only:** Not applicable; Applicable

Describe (name and location of Hotel, number of nights required, estimated rate per night, etc):

Description of hotel or other accommodation:

_____ # of nights/weeks/months at \$_____ per night/week/month = \$

Notes:

*These costs will be considered for funding support *if you must travel or temporarily relocate* within Canada or the USA to attend education/training or related clinical placement. They are in addition to the costs of tuition, registration, exams, 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: \$ _____

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):

Details of Application Category

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

- Retraining for Current Shortage:** 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 _____
- Retraining for Potential Shortage:** 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 _____
- Ongoing Professional Development:** Assist me in meeting my **ongoing requirements** for professional development.

- Rural or Remote:** 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:

Ministry Priority Areas:

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 – select at least one):

- 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:

Leadership. Describe:

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

Mailed Applications Only:

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