



# REGISTERED PSYCHIATRIC NURSES

## RPN Professional Development Fund Application Form

### Applicant Details

Name \_\_\_\_\_

Worksite \_\_\_\_\_

Department \_\_\_\_\_

Job Title / Discipline \_\_\_\_\_

Regular Employee: Y / N

Casual Employee: Y / N

Full-time: Y / N

Part-time: Y / N

Bargaining Unit \_\_\_\_\_  
(for NBA members only)

### Home Address

Street \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Work Tel \_\_\_\_\_ Home Tel \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

### Course Program

Course/Program \_\_\_\_\_

Educational Institute/Sponsoring Organization \_\_\_\_\_

Course Start Date \_\_\_\_\_

Course Completion Date \_\_\_\_\_

(Please attach a course/program outline and/or brochure describing course, times, credits etc.)

Tuition/Course Fees \_\_\_\_\_

Amount applying for \_\_\_\_\_

Who referred you to this program?

Employer

Self

Other \_\_\_\_\_

Describe why you are applying for funding. What are your career goals? How will this education contribute to your professional practice and career advancement? (200 words or less)

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Have you requested funding or time off from your employer for this program? If not, why? If denied funding, indicate why.

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If you received or anticipate receiving any funding from any other source, provide details:

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Have you previously received education funding from HSA? Y / N

If yes, please describe:

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## SIGNATURE

I confirm that all of the information provided is correct to the best of my knowledge.

Signature:

Date:

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## How to Apply

Applications will be reviewed on a rolling basis, and successful applicants will be notified shortly thereafter. Send your completed application by Fax or Email to:

Fax: 604-439-0976 c/o Sharon Link  
Email: [pd@hsabc.org](mailto:pd@hsabc.org)