

## Health Workforce New Zealand Hauora Māori Training Fund 2017

APPLICATION FORM		
<b>PERSONAL DETAILS</b>	First Name (legal name):	
	Surname (legal name):	
	Date Of Birth:	
	Gender:	Male                  Female
	Organisation Name:	
	Job Position Title:	
	Work Phone	
	Home Phone	
	Address:	
	Email address:	
	Total Hours Worked per week or FTE status:	
<b>NZ RESIDENCY STATUS</b>	<i>Do you hold New Zealand Residency Status?</i> YES    /    NO	
<b>ETHNICITY</b>	<i>Please circle</i> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>NZ Māori</span> <span>New Zealander</span> <span>Pacific Island</span> <span>Other</span> </div> <hr style="width: 100px; margin-left: auto; margin-right: 0;"/>	
<b>LINKS / WHAKAPAPA</b>	Iwi Name(s):	
	Hapū Name(s):	

## PREVIOUS QUALIFICATIONS

Please list any formal qualifications that you have obtained prior to this application.

Please include the following information:

- Name of Qualification
- Name of Training Provider (i.e. Wintec)
- Start / Finish Dates (i.e. March 2014 – Nov 2015)

Note: If no formal qualification has been obtained, please write N/A.

<b>Qualification 1</b>	
<b>Qualification 2</b>	
<b>Qualification 3</b>	

Please attach to your application the following documents:

**Course outline (information relating to your course / training programme)**

**Confirmation of Enrolment**

**Invoice / Quote relating to course fees only**

**Invoice / Quote relating to any additional course costs / resources (if available)**

## COURSE CONFIRMATION

<b>TRAINING INSTITUTE &amp; PAPERS PLANNED</b>	Training Institute Name:	
	Name of course / training programme:	
	Start Date:	
	Finish Date:	
<b>COURSE INFORMATION</b>	<p>Circle (below) the <u>level</u> of qualification for which you are seeking funding support</p> <p style="text-align: center;">CERTIFICATE                  GRADUATE CERTIFICATE                  DIPLOMA                  OTHER</p>	
<b>HEALTH PRIORITY AREA</b>	<p>Circle (below) the priority health workforce area for which you are seeking funding support</p> <p style="text-align: center;">AGED CARE                  REHABILITATION                  PRIMARY CARE                  OTHER</p> <p style="text-align: right;">_____</p>	
<b>TRAVEL</b>	<p>Will you need travel allowances to attend any classes as part of these papers?</p> <p style="text-align: center;">YES                                  NO</p> <p>If you do have to travel, what are the total kilometres between your normal workplace and your class?</p> <p style="text-align: right;">_____ kms</p>	
<b>ACCOMMODATION</b>	<p>If you travel out of town, will you need accommodation?</p> <p style="text-align: center;">YES                                  NO</p> <p>If you need accommodation, what are the estimated nights needed for 'related' accommodation?</p> <p style="text-align: right;">_____ nights</p>	
<b>RESOURCES</b>	<p>Will you need to purchase any resources for any part of these papers?</p> <p style="text-align: center;">YES                                  NO</p> <p>If you do need resources, please list them below.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

## CAREERS DEVELOPMENT PLAN

**My Long Term Goal is**

**How am I going to achieve this?**

**Short Term Plan  
(6-12 months)**

**Medium Term Plan  
(1-2 years)**

**Long Term Plan  
(3-5 years)**

# AGREEMENT SIGNATURES 2017

(Please obtain ALL relevant signatures)

## LINE MANAGER 'AGREEMENT'

In signing this application, I confirm that I have had a discussion with the applicant about their Professional Development and Career Plan and I support them in undertaking the above study and submitting this application for funding.

I have also considered the rostering implications, particularly the needs of any 'clinical' areas and agree to release the trainee for the required amount of time to attend this course.

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## APPLICANTS 'AGREEMENT'

In signing this application, I confirm that I have completed the application in full.

I accept that;

- It is my responsibility to enrol in the course
- I may be required to pay part of the costs myself, which could include but are not limited to: food, books, stationery, student union fees etc.
- I will be required to provide evidence of learning and/or completion
- If I withdraw before completing any part of the course I may be required to pay back the funding acquired
- I am responsible for informing the Waikato District Health Board Māori Health Unit of any changes to my course /training programme
- I may be contacted by the co-ordinator to provide feedback on the Hauora Māori Training Fund at any given time during the course year
- I give permission for the collection and sharing of my personal information within the Waikato DHB and the Ministry of Health for reporting purposes
- I give permission for my results to be used for Hauora Maori Training Fund reporting and promotional purposes
- I declare that I am not receiving scholarships or other funding from the Ministry of Health that covers any of the same components of this specification

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

