FBA education fund

APPLICATION FORM

Before completing this application please read the Overview of Short-Term Training Criteria document located on the HEU website: http://www.heu.org/education/fba-education-fund

SECTION A: Employee Information

ARE YOU COVERED BY THE 2014-2019 **HEALTH SERVICES & SUPPORT FACILITIES SUBSECTOR** COLLECTIVE AGREEMENT? ☐ Yes ☐ No

01 *Last Name*

02 *First Name & Initial(s)*

03 ALL CORRESPONDENCE WILL BE MAILED TO THIS ADDRESS

Street Address

Apartment/Suite Number

04 *City/Town*

05 *Province*

B C

06 *Postal Code*

07 *Area Code* *Home Phone Number* -

Area Code *Cell/pager Number* -

Area Code *Work Number* -

Extension:

08 *Email Address*

09 *Employee Number*

SECTION B: Employer Information

10 *Employer (please check one):*

☐ Vancouver Coastal ☐ Interior ☐ Providence
☐ Vancouver Island ☐ Northern ☐ Shared Services Organization
☐ Fraser ☐ Provincial ☐ Affiliate

11 *Work Site:* ____

12 *Work Site Address:* ____

13 *Union:* ____

SECTION C: Course/Program Information

14 *Name of School* [ ]

15 *Location* [ ]

16 *Course Name (and Number)* [ ]

17 *Course Hours per Week* [ ]

18 *Course Start Date (yy/mm/day)*

2	0	1						

19 *Course End Date (yy/mm/day)*

2	0	1						

20 *Confirmed?* ☐ Yes ☐ No

21 *Are you on a waitlist:* ☐ Yes *Projected Start Date:*__________________________

22 *Please explain how this course will help in your current job or future career goal in health care (within the* ***facilities subsector*** *bargaining unit):*

____

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SECTION D: Course Costs and Funding Information

23 ***Course Costs***:

Tuition: $________________________________

Lab Fee: $________________________________

Books/Materials: $________________________________

Practicum: $________________________________

Other: $________________________________

Total Course Costs: $________________________________

SECTION E: For Statistical Purposes

24 *Date of Birth:* Year _______ Month _______ Day _______

25 *Gender:* ☐ Male ☐ Female

26 *Marital Status (check one box only):*

☐ Single ☐ Single Parent ☐ Married ☐ Common-Law ☐ Separated/Divorced

27 *Number of Dependants:*

Under 18 years of age ☐ Over 18 and in full-time school/study ☐

28 *Length of Service in health care:* __________________________

29 *Current Classification (job title):* __________________________

30 *Employment Status:*

☐ Regular full-time ☐ Regular part-time ☐ Casual

31 *Regularly Scheduled Hours of Work (in a two-week pay period):* ___________________

32 *Average Casual Hours of Work (in a two-week pay period):* _______________________

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY DECLARATION FOR FUNDING APPLICATION

***Declaration** (important – read and sign):*

I declare that the information that I have provided in this application form is, to the best of my knowledge, correct and complete.

I understand that: the information I have provided will be used to determine my eligibility for funding from the FBA Education Fund.

I agree that: by signing below I give permission for the exchange of information between the FBA Education Fund, my employer, educational institutions, and other funding sources for the sole purpose of verifying and/or investigating information in this application and related documents.

I agree that: I will participate in a follow-up survey to help the FBA Education Fund determine the success of the program.

Collection and Use of the Information:

The personal information on this form will only be used for two (2) purposes:

- to determine eligibility for funding by the FBA Education Fund, and
- to gather statistics for use in reports (for example: the number of applications from care aides, the types of training funded, etc.)

Signature of Applicant: ____

Print Name: ____

Date Signed: ____

SECTION F: Checklist

☐ Confirmation of course registration and confirmed start date **attached.**

☐ Confirmation of Employee Status and Leave Approval Form **attached.**

☐ Application completed and **signed in ink.** Please note that faxed applications are not accepted.

Mail the completed application and other documentation to:

FBA Education Fund
c/o 5000 North Fraser Way
Burnaby, B.C. V5J 5M3

FBA education fund

CONFIRMATION of EMPLOYEE STATUS and LEAVE APPROVAL FORM

EMPLOYEE, PLEASE COMPLETE:

Name of Employee: ____

Position: ________________________ Dept. ___________________________

Classification: _____________________ Status: ☐ Full-time ☐ Part-time ☐ Casual

Unpaid Leave requested for the following dates or period:____________________________

Please attach a list if necessary

Total Number of Days requested: ____________________________

If no leave is required, please put N/A

Casual employees: if requesting equivalent to unpaid leave, please submit payroll proof of hours and shifts worked in the six months prior to this application or prior to your training, whichever is sooner (i.e. application date Sept. 1, 2014; proof of hours and shifts worked from Mar. 1 – Aug. 31, 2014 must be provided).

EMPLOYER, PLEASE COMPLETE:

Regular Employee status: _________ FTE (1.0, 0.5, 0.8, etc.)

Casual Employee: 488 hours of work completed? ☐ Yes ☐ No

Is this employee currently on any other leave? ☐ Yes ☐ No

If yes, please explain. ____

Is this employee covered by the 2014–2019 **Health Services & Support Facilities Subsector** collective agreement? ☐ Yes ☐ No

I, _______________ approve ____ days, or the period _____to_____of unpaid leave as requested above.
(Signature)

On behalf of the Employer,

______________________________ ______________________________
Employer Name *(please print)* Title

______________________________ ______________________________
Signature Date

Work Site Name: ____

Employer Phone: ______________________ Email: ___________________________