

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? \square Yes \square 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 Area Code Work Number
08 Email Address Extension:
09 Employee Number

SECTION B: Employer Information 10 *Employer (please check one):* Vancouver Coastal Providence Interior **Shared Services Organization** Vancouver Island Northern Affiliate Affiliate Fraser Provincial Provincial Work Site: 11 12 Work Site Address: 13 **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) **19** *Course End Date (yy/mm/day)* 2 0 1 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):

SECTION D: Course Costs and Funding Information

23	Course Costs:			
Tuition:		\$		
Lab Fee:		\$		
Books/Materials:		\$		
Practicum:		\$		
Other:		\$		
Total Course Costs:		\$		
	TION E: For Statis	·		
24	Date of Birth: Yo	ear 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:

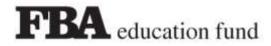
The personal information on this form will only be used for two (2) purposes:

- 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 ac	cepted.		

Mail the completed application and other documentation to:

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



CONFIRMATION of EMPLOYEE STATUS and LEAVE APPROVAL FORM

EMPLOYEE, PLEASE COMPLETE:				
Name of Employee:				
Position:				
Classification:	_ Status:			
Total Number of Days requested: Casual employees: if requesting equivalent to worked in the six months prior to this application.	Please attach a list if necessary If no leave is required, please put N/A to unpaid leave, please submit payroll proof of hours and shifts ation or prior to your training, whichever is sooner (i.e. s and shifts worked from Mar. 1 – Aug. 31, 2014 must be			
EMPLOYER, PLEASE COMPLETE:				
Regular Employee status: FTE	E (1.0, 0.5, 0.8, etc.)			
Casual Employee: 488 hours of work compl	leted? Yes No			
Is this employee currently on any other leave?				
If yes, please explain.				
Is this employee covered by the 2014–2019 I agreement? Yes No	Health Services & Support Facilities Subsector collective			
I, approve days, o	or the periodtoof unpaid leave as requested above.			
On behalf of the Employer,				
Employer Name (please print)	Title			
Signature	Date			
Work Site Name:				
Employer Phone:	Fmail:			