FBA education fund

APPLICATION FORM

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

SECTION A: Employee Information

ARE YOU COVERED BY THE 2019-2022 **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 FORM

EMPLOYEE, PLEASE COMPLETE:

Name of Employee: ____

Position: ______________________________ Dept. _________________________________

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

If Applicable:

Unpaid Leave requested for the following dates or period:_______________________________

Please attach a list if necessary or print "none"

Total Number of Days requested: ______________________________

If no leave is required, please put N/A

Casual employees: if being in attendance is required for any portion of your training, 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 April 30, 2019; proof of hours and shifts worked from Oct.. 1, 2018 – April 30, 2019 must be provided).

EMPLOYER, PLEASE COMPLETE:

Regular FT or PT 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 2019–2022 **Health Services & Support Facilities Subsector** collective agreement? ☐ Yes ☐ No

On behalf of the Employer,

____________________________________ ____________________________________

Employer Name *(please print)* Title

____________________________________ ____________________________________

Signature Date

Work Site Name: ____

Employer Phone: ________________________ Email: _____________________________

If Applicable:

I, _________________ approve _____ days, or the period ______to______of unpaid leave as requested above.

(Signature)