FBA education fund

LONG-TERM TRAINING APPLICATION FORM

SECTION A: Employee Information

ARE YOU COVERED BY THE 2010–2012 **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
☐ Vancouver Island
☐ Fraser
☐ Interior
☐ Northern
☐ Provincial
☐ Affiliate
☐ Shared Services Organization

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):*

_____

_____

_____

_____

_____

_____

_____

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.**

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

LONG-TERM TRAINING

EMPLOYEE, PLEASE COMPLETE:

Name of Employee: _____

Position: _____ Dept. _____

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

Unpaid Leave requested for the following dates: _____

*If no leave required, 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 (i.e. application date June 2010; proof of hours and shifts worked from December 2009 to May 2010 must be provided).

EMPLOYER, PLEASE COMPLETE:

Is this employee covered by the 2010–2012 **Health Services & Support Facilities Subsector** collective agreement? ☐ Yes ☐ No

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. _____

_____

_____ _____

Employer Name *(please print)* Title

_____ _____

Signature Date

Work Site Name: _____

Employer Phone: _____ Email: _____