



**SECTION B: Employer Information**

10 *Employer (please check one):*

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> Vancouver Coastal | <input type="checkbox"/> Interior   | <input type="checkbox"/> Affiliate                    |
| <input type="checkbox"/> Vancouver Island  | <input type="checkbox"/> Northern   | <input type="checkbox"/> Shared Services Organization |
| <input type="checkbox"/> Fraser            | <input type="checkbox"/> Provincial |   |

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

2	0	1								
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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.**

**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

**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: \_\_\_\_\_