

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					
---	---	---	--	--	--	--	--

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**

CONFIRMATION of EMPLOYEE STATUS and LEAVE APPROVAL FORM

SHORT-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 (*even if unpaid leave not required*):

Is 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: _____