

LONG-TERM TRAINING APPLICATION FORM

Before completing this application please read the Overview of Long-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 2012 – 2014 HEALTH SERVICES & SUPPORT FACILITIES SUBSECTOR COLLECTIVE AGREEMENT? Yes No

01 Last Name

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02 First Name & Initial(s)

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03 ALL CORRESPONDENCE WILL BE MAILED TO THIS ADDRESS

Street Address

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Apartment/Suite Number

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

04 City/Town

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

05 Province

B	C
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06 Postal Code

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

07 Area Code

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Home Phone Number

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Area Code

--	--	--

Cell/pager Number

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

Area Code

--	--	--

Work Number

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

Extension:

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

08 Email Address

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09 Employee Number

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SECTION B: Employer Information

10 Employer (please check one):

- Vancouver Coastal
- Vancouver Island
- Fraser
- Interior
- Northern
- Provincial
- Providence
- Shared Services Organization
- 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																	
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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):

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 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 or period: _____

Please attach a list if necessary

Total Number of Days requested: _____

If no leave is required, please 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 or prior to your training, whichever is sooner (i.e. application date July 2013; proof of hours and shifts worked from Jan. 1 – June 30, 2013 must be provided).

EMPLOYER, PLEASE COMPLETE:

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. _____

Is this employee covered by the 2012–2014 **Health Services & Support Facilities Subsector** collective agreement? Yes No

I, _____ approve _____ days, or the period _____ to _____ of unpaid leave as requested above.
(Signature)

On behalf of the Employer,

Employer Name (please print)

Title

Signature

Date

Work Site Name: _____

Employer Phone: _____ Email: _____