



**SECTION B: Employer Information**

10 Employer (please check one):

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

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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**

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 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).

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