



## CLINICAL TRAINING AGENCY FUNDING APPLICATION FORM

### CTA Funding Postgraduate Study for Registered Nurses 2009

1. PERSONAL DETAILS			
NAME:			
Annual Practising Certificate (APC) Number:		DOB: ___/___/___	
Expiry Date:			
Name of APC if different to name above:			
POSTAL ADDRESS:			
PHONE:	(Work)	(Home)	(Mobile)
EMAIL: <i>(Please include as this is main form of communication)</i>			
CURRENT NURSING POSITION:		Location:	
CURRENT EMPLOYER:		FTE (hours per week):	
SECONDARY NURSING POSITION:		Location:	
SECONDARY EMPLOYER:		FTE (hours per week):	
Duration of Current Employment:		Duration of Secondary Employment:	
_____ years _____ months		_____ years _____ months	
<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Casual		<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Casual	
Please identify your previous employer if you have been employed less than 12 months			
Name:			
Address:			

## 2. EDUCATIONAL QUALIFICATIONS

Current Nursing Postgraduate Qualification(s):			
Programme	Educational Institution	Qualification e.g. HSc	Date Completed
Post Graduate Cert			
Post Graduate Dip			
Masters			

## 3. PROPOSED COURSE OF STUDY

**N.B** *priority will be given to applicants that have:*

- *A clear pathway towards a proposed qualification*
- *not received previous funding for papers and have not completed / withdrawn / failed.*

Name of Education Provider:

Have you enrolled?       Yes       No

Qualification you intend to complete:

POST GRADUATE CERTIFICATE

POST GRADUATE DIPLOMA

MASTERS

MASTERS WITH PRESCRIBING

Will you complete the qualification in 2009?       Yes       No

If NO – when?

## 4. PAPERS YOU INTEND TO COMPLETE IN 2009

Semester One		Semester Two	
Course Name:	Credit:	Course Name:	Credit:
Course Name:	Credit:	Course Name:	Credit:

Have you applied for CTA funding previously for any of the papers you intend to complete in 2009?

Yes       No

**If yes, please indicate:**

5. OUTLINE OF ACADEMIC PLAN TO COMPLETE IDENTIFIED QUALIFICATION	
<b>FOR EXAMPLE</b>	
1. Assessment and diagnostic reasoning	30 credits
2. Applied Science	15 credits
3. Pharmacology	15 credits
<b>6. COSTS</b>	
<b>Tuition Fees:</b> (must include estimated cost)	\$ _____
<b>Travel and Accommodation Required</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<i>NB: Funding will not cover all costs and is a subsidy only</i>	
<b>Distance from place of work to Education Provider</b> (one way)	<b>&lt;100kms / 100-250kms / &gt; 250kms</b> (please circle)
<b>Clinical Release (Study Days)</b> <i>Please note funding is a subsidy only</i>	_____ (No. of days)
<b>Clinical Access</b> <i>(NP Prescribing Practicum only)</i>	----- (No. of days)
<b>Has assistance been requested from other funds:</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>If so, which funds:</b>	
<b>Was funding received?</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>If yes, amount received:</b>	\$ _____
<b>7. STATISTICAL INFORMATION</b>	
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Age</b>	<input type="checkbox"/> Under 24 years <input type="checkbox"/> 25-29 years <input type="checkbox"/> 30-34 years <input type="checkbox"/> 35-39 years <input type="checkbox"/> 40-44 years <input type="checkbox"/> 45 years plus
<b>Ethnicity</b>	<input type="checkbox"/> Maori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Tokelauan <input type="checkbox"/> Fijian <input type="checkbox"/> Other Pacific <input type="checkbox"/> NZ European/Pakeha <input type="checkbox"/> South East Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other

<b>8. DECLARATION / CHECKLIST (all categories must be completed)</b>		
1.	Do you have a current practicing certificate?	<input type="checkbox"/> <b>Yes</b>
2.	Are you a New Zealand Citizen or NZ Resident?	<input type="checkbox"/> <b>Yes</b>
3.	Copy of study/course information attached	<input type="checkbox"/> <b>Yes</b>
4.	Programme of study and study leave approved by manager (page 5)	<input type="checkbox"/> <b>Yes</b>
5.	Does the study contribute to your short/long term goals?	<input type="checkbox"/> <b>Yes</b>
6.	How?	

**7. MANAGER SUPPORT**

<b>Management Considerations:</b>		
1.	Is this study relevant to the learning needs/career plan of the staff member?	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
2.	Is this study consistent with identified clinical priorities and service goals/direction for the organisation?	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
3.	Does this individual contribute to the organisation (e.g. resource role, preceptor, clinical leadership, protocol development etc)?	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
4.	Do you support the applicant to undertake this programme/paper(s) and release them for study days?	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>

Comment, justification and recommendation:

**SIGNED BY:**

**Manager:**.....(print name)

.....(signature) **Date:**.....

**If your application is successful there is an expectation that you will:**

- Successfully complete the course.
- Feedback knowledge gained to relevant nursing and midwifery forums through teaching sessions both in clinical settings and wider education settings and/or complete a quality improvement related to study undertaken.
- If you need to withdraw from a paper/study you will make every effort to contact the tertiary institution prior to withdrawal cut off date.

**By signing this application I agree that:**

- I will enrol into the university within the university timeframes.
- I will contact the Nurse Educator – Professional Development at NDHB of **ANY** changes in my enrolment in writing.
- Failure to complete the Post Graduate Qualification I have indicated (for reasons other than those beyond fair and reasonable causes) may result in repayment of the monies received.
- NDHB can seek confirmation of course completion and grade from the university involved.
- I have discussed my application with my employer/nurse manager re: appropriateness of papers.
- My name may be forwarded to others so that other students can contact me to discuss the papers I have completed or are currently undertaking.
- I agree that if I am unsuccessful in my application then my name can be placed on a shortlist.

**Applicant's Name:** .....

**Signature:** ..... **Date:** .....

**9. FINAL CHECKLIST**

- I have read all the information provided
- Completed the application form
- Copy of study/course information attached
- Signed the appropriate areas
- Have manager sign off and support

**Please forward the completed documentation to:**

**Sheryll Beveridge  
Nurse Educator – Professional Development  
Nursing & Midwifery Directorate  
Northland DHB  
PO Box 742, Whangarei  
Phone: 09 430 4101 extn 7214 or 021 447193  
Email: sheryll.beveridge@northlanddhb.org.nz**