

**LONG-TERM TRAINING APPLICATION FORM**

**Deadline: October 28, 2011**

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 2010–2012 **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*

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**04 City/Town**

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**05 Province**

B	C
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**06 Postal Code**

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**07 Area Code Home Phone Number**

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*Area Code Cell/pager Number*

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*Area Code Work Number*

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**08 Email Address**

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*Extension:*

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**09 Employee Number**

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**SECTION B: Employer Information**

**10 Employer (please check one):**

- Vancouver Coastal       Interior       Affiliate  
 Vancouver Island       Northern       Shared Services  
 Organization  
 Fraser       Provincial

**11 Work Site:**

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**12 Work Site Address:**

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**13 Union:**

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**SECTION C: Course/Program Information**

**14 Name of School**

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**15 Location**

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**16 Course Name (and Number)  
Week**

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**17 Course Hours per**

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**18 Course Start Date (yy/mm/day)  
(yy/mm/day)**

**19 Course End Date**

2	0	1									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:

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Print Name:

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Date Signed:

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**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:

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Position: \_\_\_\_\_ Dept.

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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).

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**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. \_\_\_\_\_

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Employer Name *(please print)*

Title

\_\_\_\_\_

Signature

Date

Work Site Name: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Email: \_\_\_\_\_