



## HEALTH SCIENCE PROFESSIONALS

HSPBA Professional Development Fund

### Application Form

- For education/training commenced between September 1, 2018 and December 31, 2019
- Application Form to be submitted ASAP and no later than September 1, 2019

#### Applicant Details

I have read the [FAQ \(Frequently Asked Questions\)](#) document

Name: \_\_\_\_\_

Worksite: \_\_\_\_\_

Employer:  NHA  IHA  FHA  VCH

VIHA  PHSA  PHC

Lower Mainland Consolidated Service, specifically: \_\_\_\_\_

Other (describe): \_\_\_\_\_

Discipline: \_\_\_\_\_  
(e.g. Physiotherapist, Psychologist)

Job title: \_\_\_\_\_

Department/Program/Team name: \_\_\_\_\_

Employment status:  Regular Full-time or Part-time  Casual

Temporary - temporary term end date: \_\_\_\_\_

#### Contact Information

Home address: \_\_\_\_\_  
(STREET ADDRESS----- CITY-----POSTAL CODE)

Daytime home/cell number: \_\_\_\_\_

Phone number at work: \_\_\_\_\_

Personal email address: \_\_\_\_\_

*Note: Your decision letter will be sent to your personal email address*

#### Description of Education/Training for which Funding Support is Requested

Identify the type(s) of professional development event/instruction:

Workshop             Course             Seminar             Program

Conference             Clinical Placement     Distance Learning

Other – describe: \_\_\_\_\_

Name of course(s), workshop, or instruction event:

Name of education/training provider/institute:

Course Delivery (i.e. in-person, or online, or a combination):

Location of course: \_\_\_\_\_  
*City and Province; City and USA State; or City & other international country*

Start date(s) for event(s)/course(s)/instruction:

Completion date(s) for requested event(s)/course(s)/instruction:

Registration deadline, if applicable: \_\_\_\_\_

Yes, I have attached the education provider’s outline of, or link to, the requested event/instruction. The web link is:

Describe the event’s/instruction’s content as serving the following professional development purpose:

**Other notes:**

**Part A: Cost of Education/Training for which Funding Support is Requested**

If you are applying for funding support for the cost of education *outside Canada*, i.e. within the U.S.A. or other international country, please provide your rationale, eg. describe how the education/training is highly specialized and not available within Canada:

**Cost of tuition fees**

Not applicable

Description:

Amount \$

**Cost of registration fees**

Not applicable

Description:

Amount \$

**Cost of exam fees**

Not applicable

Description:

Amount \$

**Cost of required books/materials**

Not applicable

Description:

Amount \$

**Cost of other reasonable education/training-related expenses**

Not applicable

Description:

Amount \$

Notes :

**Total dollar amount requested for Part A costs: \$ \_\_\_\_\_**

**Part B: \*Cost of Travel and Accommodation Within Canada or the USA to Access Education/Training**

If you are applying for funding support for the cost of travel and accommodation **outside Canada**, i.e. within the U.S.A., please provide your rationale, eg. describe how the education/training is highly specialized and not available within Canada:

**\*Cost of travel – within Canada or the USA only:**       Not applicable;    Applicable

Economy Airfare: From \_\_\_\_\_ to \_\_\_\_\_ \$

Ferry/reservation: From \_\_\_\_\_ to \_\_\_\_\_ \$

Parking: \_\_\_\_\_ # of days x \_\_\_\_\_ rate per day = \$

Transit: \_\_\_\_\_ # of days x \_\_\_\_\_ rate per day = \$

Mileage (home to/from education): \_\_\_\_\_ km @ \$0.58 per km = \$

Other: \_\_\_\_\_ \$

Notes:

**\*Cost of accommodation – within Canada or the USA only:**       Not applicable;    Applicable

Describe (name and location of Hotel, number of nights required, estimated rate per night, etc):

Description of hotel or other accommodation:

\_\_\_\_\_ # of nights/weeks/months at \$ \_\_\_\_\_ per night/week/month = \$

Notes:

\*These costs will be considered for funding support *if you must travel or temporarily relocate* within Canada or the USA to attend education/training or related clinical placement. They are in addition to the costs of tuition, registration, required books/materials, and other reasonable education/training-related expenses.

**Total dollar amount requested for Part B costs: \$ \_\_\_\_\_**

**TOTAL DOLLAR AMOUNT REQUESTED FOR BOTH PART A and B COSTS: \$ \_\_\_\_\_**

## Funding From Any Other Source

I have received or anticipate receiving some funding support for this same event/instruction from another source:  No  Yes. If yes, please provide the amount and describe the funding support(s):

## Details of Application Category

My application, if approved, would serve to (please check all applicable categories):

- Retraining for Current Shortage:** Help to retrain me for a health science profession for which there is a shortage. Examples include:
- Physiotherapist       Occupational Therapist       Sonographer
- Perfusionist       Other: please specify \_\_\_\_\_
- Retraining for Potential Shortage:** My application, if approved, would retrain me for a health science profession **that may experience shortages and will contribute to the inter-professional team** in Ministry of Health priority areas such as Primary Care Services, Adults with Complex Medical Conditions and/or Frailty, Surgical and Diagnostic Services, Mental Health and Substance Use Services, Anesthesia Services, Palliative Care, and Indigenous Health.
- Examples include:
- Psychologist       Psychosocial Rehabilitation       Speech Language Pathologist
- Social Worker       Trained Peer Support       Aboriginal Patient Liaison/Navigator
- MRI Technologist       Anesthesia Assistant       Cross-Cultural Liaison
- Pharmacist       Dental Hygienist       Recreation Therapist
- Nutritionist       Dietitian       Public Health Expert
- Counsellor       Clinical Counsellor       Vocational Counsellor
- Music Therapist       Art Therapist
- Other: please specify \_\_\_\_\_
- Ongoing Professional Development:** Assist me in meeting my **ongoing requirements** for professional development.

- Rural or Remote:** Enhance my professional development opportunities as a health science professional working specifically in a **rural or remote area**.

Please state the name of the community in which your rural or remote worksite is located, as well as the name(s) of any other community (including First Nations communities) to which you travel to provide service:

**Ministry Priority Areas:**

Indicate below how your proposed training/professional development will prepare you to contribute to one or more of the following Ministry priority areas (check all relevant areas – select at least one):

- Primary Care Services. Describe:

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- Adults with Complex Medical Conditions and/or Frailty. Describe:

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- Surgical and Diagnostic Services. Describe:

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- Mental Health and Substance Use Services. Describe:

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- Anesthesia Services. Describe:

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Palliative Care. Describe:

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Indigenous Health. Describe:

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Leadership. Describe:

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### Signature and How to Submit Your Application

Applications will be considered for funding support **in the order they are received**, while funds last.

I confirm that all information provided in this application is true and correct to the best of my knowledge.

**Please select one of the following two methods** to submit your completed application to CUPE. Method One offers administrative efficiencies that will speed up processing of an application.

### Method One

- **Instructions:**

- Download the application form
- Complete the application form electronically
- Save the completed form in .PDF format *only*
- Attach and email the saved form to:
  - If you are a member of CUPE 15, to Mark Gloumeau: [mgloumeau@cupe15.org](mailto:mgloumeau@cupe15.org)
  - If you are a member of CUPE 1978, to Lindsay Fumalle: [lindsay.fumalle@cupe1978.com](mailto:lindsay.fumalle@cupe1978.com)
  - If you are a member of CUPE 4816, to Connie Penman: [conniepenman@shaw.ca](mailto:conniepenman@shaw.ca)

## Method Two

- **Instructions:**

- Download the application form
- Complete the application form electronically
- Print the completed form and mail it to:

Chris Losito, Health Coordinator  
Canadian Union of Public Employees  
B.C. Regional Office  
6222 Willingdon Avenue  
Burnaby, B.C. V5H 0G3  
Attention: Professional Development Fund

### **Mailed Applications Only:**

If you print the completed form and mail it to the CUPE office, your signature and date are required:

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Signature

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Date signed

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### **Privacy Statement**

CUPE is committed to using the personal information we collect in accordance with applicable privacy legislation. By completing this form you are consenting to have CUPE use the submitted information for the purposes of conducting our representational duties as a union, and in providing services to our members. For further information please contact CUPE Health Coordinator Chris Losito at [closito@cupe.ca](mailto:closito@cupe.ca).