

APPLICATION FORM

Checklist

Confirmation of Employee Status	Copy of current job description and wage rate
Program outline and course description	Course fee breakdown
Application completed and signed	

Checklist Upon approval

Proof of enrollment (acceptance letter)	Expense form including: <ul style="list-style-type: none"> Printout showing school name and courses taken Printout showing cost for courses taken Itemized receipts for textbook purchases or "other expenses" Proof of payment (credit card slip or statement, bank statement, receipt, etc.)
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ADDITIONAL INFORMATION SUCH AS A JOB DESCRIPTION IN THE AREA THAT YOU ARE LOOKING TO MOVE INTO MAY BE REQUESTED.

Employee Information

Last Name:	First Name and Initial(s):
Address:	City/Town:
Province:	Postal Code:
ALL CORRESPONDENCE WILL BE MAILED TO THIS ADDRESS	
Preferred Phone Number:	E-Mail Address:
Are you covered by the 2022-2025 community health subsector collective agreement? YES NO	
Did you lose your job as a result of lay off due to contracting out or retendering? YES NO	
<div style="text-align: right; margin-right: 50px;"> ↳ If YES, date of lay off: </div>	
Name of employer at time of layoff:	

Employer Information

Employer (please check one):

Vancouver Coastal Health Authority	Fraser Health Authority	Northern Health Authority
Vancouver Island Health Authority	Interior Health Authority	Provincial Health Services Authority Affiliate

Worksite:

Worksite Address:

Union:	Job Title:	Wage Rate:
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Course/Program Information

Name of School:

Location:

Course Name (and Number):

Course Hours per week:

Course Start Date (yy/mm/day):

Course End Date (yy/mm/day):

Funding Amount Requested (Please provide breakdown of course and costs):

Course Name

Course Cost

Please explain why you have selected this course or program and how it relates to continued employment in the Community Health Sector or to upgrading your skills in your current position.

MONIES WILL NOT BE PAID OUT TO FUND DEGREE PROGRAMS WHERE THE JOB DESCRIPTION DOES NOT REQUIRE IT. A LIMITED NUMBER OF RELEVANT COURSES WITHIN A DEGREE PROGRAM MAY BE CONSIDERED ON A CASE-BY-CASE BASIS. THE APPLICANT WILL BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.



APPLICATION FORM

Freedom of information and protection of privacy – Declaration for funding application

I declare that: The information that I have provided in this application form is, to the best of my knowledge, correct and complete.

I agree that: I may be asked to repay some or all of the monies which have been funded to me by the Joint Community Health Retraining Fund (The Fund) if I fail to complete a course, or courses, without justification.

I recognize that: if I receive money from the Joint Community Health Retraining Fund, and I have received Employment Insurance (EI) as a result of a layoff, EI may attempt to recover the monies paid to me. Please contact your local EI Office for further details.

I understand that: The information I have provided will be used to determine my eligibility for funding from the Joint Community Health Retraining Fund.

I agree that: by signing below I give permission for the exchange of information between The 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 Joint Community Health Retraining Fund committee determine the success of the program.

I agree that: I will stay in the health sector for a minimum of 3 times the length of retraining or be responsible for repayment.

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 CBA Retraining Fund; and
- to gather statistics for use in reports (for example: the number of applications from care aides, the types of training funded, etc.)

I agree to all of the terms & conditions listed above.

Date:

Print Name:

Send the completed application and other documentation to:

Email: chrhf@bcgeu.ca	Mail: Attention: Fund Administrator, CHRF B.C. Government and Service Employees' Union 4911 Canada Way Burnaby, BC V5G 3W3	Fax: 604-291-6030
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For more information on the Joint Community Health Retraining Fund, visit jointchrhf.ca

Telephone: 604-291-9611 • Toll Free: 1-800-663-1674

