Joint COMMUNITY HEALTH RETRAINING FUND

APPLICATION FORM

Complete this form in ink (please print clearly) and ATTACH the following:

- ☐ Current Job Description with your hourly wage
- ☐ Confirmation of Employee Status Form

If course already completed:

- ☐ Proof of *registration* for the retraining program/course
- ☐ Proof of *payment* (original documents only) for the retraining program and course materials
- ☐ Proof of retraining program *completion*

- OR –

If course not yet completed:

- ☐ Proof of *acceptance* or *registration* for the retraining program/course is preferred. Proof of payment will be required prior to funds being released
- ☐ Course Fee Breakdown

Note: the administrator may require you to provide additional information such as a job description in the area that you are looking to move into

JOINT COMMUNITY HEALTH RETRAINING FUND APPLICATION FORM

SECTION A: Employee Information

- ARE YOU COVERED BY THE 2019-2022 **COMMUNITY HEALTH SUBSECTOR** COLLECTIVE AGREEMENT? ☐ Yes ☐ No

- DID YOU LOSE YOUR JOB AS A RESULT OF LAY OFF DUE TO CONTRACTING OUT OR RETENDERING?
  IF SO, DATE OF LAY OFF _____

  NAME OF EMPLOYER AT TIME OF LAYOFF _____

_____

1. *Last Name*

_____

2. *First Name and Initial(s)*

_____

ALL CORRESPONDENCE WILL BE MAILED TO THIS ADDRESS

3. Street Address/Box or Apartment Number

_____

4. *City/Town*

_____

5. *Province*

_____

6. *Postal Code*

_____

7. *Area Code* *Home Phone Number*

_____ _____

Area Code *Cell/Pager Number*

_____ _____

Area Code *Work Number*

_____ _____

Extension

8. *E-Mail Address*

_____

_____

SECTION B: Employer Information

9. *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

10. *Worksite*:_____

11. *Worksite Address:*_____

12. *Union:*_____

13. *Job Title:*_____

14. *Wage Rate:*_____

_____

SECTION C: Course/Program Information

15. *Name of School*

_____

16. *Location*

_____

17. *Course Name (and Number)*

_____

18. *Course Hours per week*

_____

19. *Course Start Date (yy/mm/day)*

_____

20. Course End Date (yy/mm/day)

_____

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

Course Name	*Course Cost*

Note: 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.

22. *Please explain why you have selected this course or program and how it relates to continued employment in the Community Health Sector (Note: if you are applying to a private institution or for private training, please provide your reasons here):*

_____

_____

_____

_____

_____

_____

_____

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 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.)

Signature of Applicant: _____ Date Signed:_____

Print Name:_____

SECTION E: Checklist *(to ensure quick processing of your application please include all of the following with your application form)*

☐ Confirmation of course registration

☐ Confirmation of Employee Status

☐ Current Job Description and wage rate

☐ Course fee breakdown

☐ **Application completed and signed in ink**

Send the completed application and other documentation to:
Attention: Fund Administrator
B.C. Government and Service Employees' Union
4911 Canada Way
Burnaby, BC V5G 3W3
Telephone: 604-291-9611 Toll Free: 1-800-663-1674 Fax: 604-291-6030
Email: chrf@bcgeu.ca

MoveUp Rev: March 2019