Allied Health & Nursing Staff CPD

Funding Program Application

In light of Covid-19, Continuing Professional Development (CPD) Funding will be available from July 2020 to support costs associated with registration (only) for professional development activities (either online or face:face). Please refer to the CPD Program Funding Guidelines for full eligibility criteria. *Please note*: Funding to support tertiary education fees is provided via a separate program. Funding is not currently available to support travel and accommodation.

APPLICANT DETAILS			
NAME:		**CONTACT NUMBER:**	
PROFESSION:		**DEPARTMENT:**	
POSITION:			
RCH EFT:		**IS RCH YOUR SOLE EMPLOYMENT?**	

CPD ACTIVITY DETAILS			
TYPE OF ACTIVITY:		**YOUR ROLE:**	
ACTIVITY NAME:			
DATE(S):		**DELIVERY MODE:** (ONLINE and/or FACE:FACE)	
IS THIS ACTIVITY ONCOLOGY-RELATED			☐ YES ☐ NO

Please note that any oncology related activities require co-signing at Tier 1 by Damien Roberts, who can then submit the application on your behalf for Tier 2 endorsement and Committee review. If your application is not related to oncology, please disregard this requirement.

FUNDING REQUEST		
Item	*Description of Item*	*Amount requested*
CPD registration fees		$ 0.00
Other		$
Other		$
TOTAL AMOUNT OF FUNDING REQUESTED:		$ **0.00**
OTHER FUNDING		
Have you received CPD funding from this program in the past 12 months?		☐ YES ☐ NO
If yes, please specify the date, activity and amount(s):		
Are you eligible for any other sources of funding for this activity?		☐ YES ☐ NO
If yes, please specify the source and amount(s):		

Allied Health & Nursing Staff CPD

Funding Program Application

ANTICIPATED BENEFITS & DISSEMINATION OF KNOWLEDGE
HOW DO YOU ANTICIPATE THAT PARTICIPATION IN THIS CPD ACTIVITY WILL LEAD TO CLINCIAL INNOVATION AND/OR INFLUENCE YOUR CLINICAL PRACTICE TO IMPROVE PATIENT OUTCOMES AT RCH? (i.e. How does this activity support your current position and professional development goals, as well as benefit your wider unit/department/service delivery at RCH?)
HOW DO YOU ANTICIPATE YOU WILL SHARE YOUR LEARNINGS WITH YOUR COLLEAGUES? (e.g. Ward in-service; Department Meeting; Newsletter; Development of Guidelines or processes)

CHECKLIST FOR ENDORSEMENT (Present all documents below to your line manager with this form)

- ☐ Completed & signed CPD Funding Application form
- ☐ Agenda and/or program for the CPD activity, showing evidence of costs
- ☐ Other supporting evidence (e.g. evidence of accepted presentation, etc).

APPLICANT DECLARATION			
I declare that: • All the information I have provided in this application is true and correct. • All costs incurred will be my personal costs only. • I have provided all necessary documentation. • I understand that I will be required to provide a written report (using the CPD Activity report Form) at 3 months following the completion of all funded activity.			
SIGNATURE:		**DATE:**	

Allied Health & Nursing Staff CPD

Funding Program Application

Please note that once an application has been endorsed at Tier 1 and 2 it is an individual's responsibility to submit an application.

HEAD OF DEPARTMENT/MANAGER/NURSE UNIT MANAGER/DIRECTOR (TIER ONE)			
NAME:		**TELEPHONE:**	
POSITION:		**DEPARTMENT:**	
SIGNATURE:		**DATE:**	

Is this CPD activity aligned and relevant to the applicant's current position at RCH? Will the knowledge and skills learned as a result of this activity be applicable to the applicant's current role and responsibilities? Is the activity aligned with the applicant's PDAP?	☐ YES ☐ NO
Is this CPD activity aligned with the priorities of the Department and RCH Strategic Plan?	☐ YES ☐ NO
Will participation in this CPD activity support clinical innovation and improved outcomes for RCH patients? Will the applicant's participation in this activity contribute to service delivery and delivery of patient/family care at RCH?	☐ YES ☐ NO
Will the applicant receive any funding for this activity from the Department?	☐ YES ☐ NO
If yes, please specify the amount:	
I confirm that I have sighted all relevant supporting documentation and approve the costs as appropriate and in compliance with RCH policies and practices. Supporting documents should include CPD agenda/program (indicating registration costs)	☐ YES ☐ NO
Is the applicant up to date with all RCH mandatory training requirements?	☐ YES ☐ NO
Is the applicant up to date with their PDAP?	☐ YES ☐ NO
If YES, date of last PDAP?	

STATEMENT OF SUPPORT *(Please make a statement in support of the suitability of this funding application to the role and responsibilities of the applicant and any recommendation for proportionate funding, where relevant)*

ONCOLOGY-RELATED ACTIVITY ONLY (TIER 1 CO-SIGNATORY)			
Please skip co-signatory if your application is not for an oncology-related activity.			
NAME:	**Damien Roberts**	**TELEPHONE:**	**57963**
POSITION:	**Operations Manager**	**DEPARTMENT:**	**Children's Cancer Centre**
SIGNATURE:		**DATE:**	

AHNEDLP COMMITTEE DIRECTOR (TIER TWO)			
NAME:		**POSITION:**	
SIGNATURE:		**DATE:**	
APPLICATION ENDORSED:	☐ YES ☐ NO	**If yes, confirm amount:**	

Please email your completed and appropriately signed application form, with supporting documents, as one document to AlliedHealth-Nursing.Education@rch.org.au. (Hardcopy applications will not be considered).