**Please attach to your application ALL the following documents:**

**Course outline (information relating to your course / training programme)**

**Confirmation of Enrolment**

**Invoice / Quote relating to course fees only**

**Invoice / Quote relating to any additional course costs / resources (if available)**

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| **HAUORA MAORI TRAINING FUND APPLICATION FORM** | | |
| **PERSONAL DETAILS** | First Name (legal name): |  |
| Surname (legal name): |  |
| Date Of Birth: |  |
| Gender: | Male Female |
| Organisation Name: |  |
| Job Position Title: |  |
| Work Phone |  |
| Home Phone |  |
| Address: |  |
| Email address: |  |
| Total Hours Worked per week or FTE status: |  |
| **NZ RESIDENCY STATUS** | *Do you hold New Zealand Residency Status?* YES / NO | |
| **ETHNICITY** | *Please circle*  NZ Māori New Zealander Pacific Island Other  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | |
| **LINKS / WHAKAPAPA** | Iwi Name(s): |  |
| Hapū Name(s): |  |

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| **COURSE CONFIRMATION** | | |
| **TRAINING INSTITUTE & PAPERS PLANNED** | Training Institute Name: |  |
| Name of course / training programme: |  |
| Start Date: |  |
| Finish Date: |  |
| **COURSE INFORMATION** | *Circle (below) the level of qualification for which you are seeking funding support*  CERTIFICATE GRADUATE CERTIFICATE DIPLOMA OTHER | |
| **HEALTH PRIORITY AREA** | *Circle (below) the priority health workforce area for which you are seeking funding support*  AGED CARE REHABILITION PRIMARY CARE OTHER  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | |
| **TRAVEL** | *Will you need travel allowances to attend any classes as part of these papers?*  YES NO | |
|  | *If you do have to travel, what are the total kilometres between your normal workplace and your class?*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ kms | |
| **ACCOMMODATION** | *If you travel out of town, will you need accommodation?*  YES NO | |
|  | *If you need accommodation, what are the estimated nights needed for ‘related’ accommodation?*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ nights | |
| **RESOURCES** | *Will you need to purchase any resources for any part of these papers?*  YES NO | |
|  | *If you do need resources, please list them below.*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **CAREERS DEVELOPMENT PLAN** | |
| **My Long Term Goal is** |  |
| **How am I going to achieve this?** | |
| **Short Term Plan**  **(6-12 months)** |  |
| **Medium Term Plan**  **(1-2 years)** |  |
| **Long Term Plan**  **(3-5 years)** |  |

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| **PREVIOUS QUALIFICATIONS** | |
| **Please list any formal qualifications that you have obtained prior to this application.**  Please include the following information:   * Name of Qualification * Name of Training Provider (i.e. Wintec) * Start / Finish Dates (i.e. March 2014 – Nov 2015)   Note: If no formal qualification has been obtained, please write N/A. | |
| **Qualification 1** |  |
| **Qualification 2** |  |
| **Qualification 3** |  |

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| **AGREEMENT SIGNATURES**  (Please obtain ALL relevant signatures) | |
| **LINE MANAGER ‘AGREEMENT’** | In signing this application, I confirm that I have had a discussion with the applicant about their Professional Development and Career Plan and I support them in undertaking the above study and submitting this application for funding.  I have also considered the rostering implications, particularly the needs of any ‘clinical’ areas and agree to release the trainee for the required amount of time to attend this course.  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_/ \_\_\_ |
| **APPLICANTS ‘AGREEMENT’** | In signing this application, I confirm that I have completed the application in full.  I accept that;   * **It is my responsibility to enrol in the course** * **It is my responsibility to provide all documents that are listed at the top of page one** * **I may be declined from receiving Hauora Maori Training Fund** * **No payments will be made unless I have provided all documents and have received an acceptance letter by the Hauora Maori Training Fund co-ordinator** * **I will be contacted by the co-ordinator to provide feedback on the Hauora Māori Training Fund at any given time during the course year** * I may be required to pay part of the costs myself, which could include but are not limited to: food, books, stationery, student union fees etc. * I will be required to provide evidence of learning and/or completion * If I withdraw before completing any part of the course I may be required to pay back the funding acquired * I am responsible for informing the Waikato District Health Board Māori Health Unit of any changes to my course /training programme * I give permission for the collection and sharing of my personal information within the Waikato DHB and the Ministry of Health for reporting purposes * I give permission for my results to be used for Hauora Maori Training Fund reporting and promotional purposes * **I declare that I am not receiving scholarships or other funding from the Ministry of Health that covers any of the same components of this specification**   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_/ \_\_\_ |