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| ALLIED HEALTH ASSISTANT SCHOLARSHIP PROGRAM 2020 |
| Application Form |

The HETI Allied Health Assistant Scholarship Program provides funding to support the training of Allied Health Assistants (AHAs) and Pharmacy Assistants and Technicians (PATs) seeking to further develop their knowledge and skills. Eligible AHAs and PATs are able to apply for one-off funding to support their enrolment in the Certificate IV in Allied Health Assistance or the Certificate IV in Hospital/ Health Services Pharmacy Support, which will enhance their ability to perform their current work role.

Both qualifications are offered by TAFE NSW in the online delivery mode with some connected learning involving online sessions with teachers.

The Certificate IV Allied Health Assistance is offered in the following specialisations:

* Nutrition and Dietetics
* Physiotherapy
* Occupational Therapy
* Physiotherapy/Occupational Therapy – combined

In addition, TAFE Gosford will deliver two single units of competency in an online delivery mode.

The single units offered will be:

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| * HLTAHA017 Assist with Social Work | * CHCMHS001 Work with people with mental health issues |

Applicants are invited to apply for either of the full qualifications, or one or two of the single units.

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| SUBMITTING AN APPLICATION | ENQUIRIES |
| Before submitting your application, please ensure you have:   * Read the Terms and Conditions of the program * Completed all parts of this application form * Obtained **all** necessary signatures from designated people   To submit the application, email the completed and signed application form to: [HETI-Scholarships@health.nsw.gov.au](mailto:HETI-Scholarships@health.nsw.gov.au)  Applications must be received by COB on **Friday 21 August 2020**  *Applicants will receive email notification of receipt following submission of application. Late or incomplete applications will not be presented to the Review Committee* | **Sue Aldrich**  🕾 0437 471 886  🖂 [HETI-Scholarships@health.nsw.gov.au](mailto:HETI-Scholarships@health.nsw.gov.au) |

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| APPLICANTS DETAILS | |
| **Name:** |  |
| **Position:** |  |
| **Organisation:** |  |
| **Work Address:** |  |
| **Work Telephone:** |  |
| **Work Email Address:** |  |

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| ELIGIBILITY CRITERIA |
| **To be eligible to apply for the grant, applications must meet ALL of the following criteria:**   1. The applicant is working as an AHA or PAT or following training would work, under the supervision of an allied health professional(s) in one or more of the following allied health areas:  |  |  |  | | --- | --- | --- | | Occupational therapy | Physiotherapy | Pharmacy | | Dietetics | Speech pathology | Podiatry | | Social Work  Recreation Therapy | Radiography | Audiology |  1. The applicant is permanently employed by NSW Health. Applicants who are not permanent NSW Health staff but who have worked as temporary or casual staff inside the LHD/SHN for more than 12 months, may apply if endorsed by their line manager. HETI will consider these applications at their discretion. 2. The applicant is seeking to enrol in a full qualification from the Certificate IV in Allied Health Assistance or the Certificate IV in Hospital/Health Services Pharmacy Support, or available single units. 3. The applicant is supported by their line manager. 4. The Allied Health Director or Director of Pharmacy of the LHD/SHN has been made aware of the nomination.   Applicants must demonstrate that the training is relevant to their current or planned role within NSW Health through addressing the selection criteria.  **SELECTION CRITERIA**  Each eligible application will be assessed on **merit and quality** by the application review committee against the following **selection criteria**:   1. Description of what the applicant hopes to achieve from completion of the training. 2. Description of the need for and relevance of this training for the applicant’s current or planned role and how the skills and knowledge gained from the training will benefit the applicant’s workplace and the applicant personally. 3. Declaration that the applicant’s responses to the selection criteria are written by the applicant in their own words. 4. Line manager endorsement including an indication that the Director of Allied Health or Director of Pharmacy has been made aware of the application. |

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| HOW THE APPLICANT MEETS ELIGIBILITY CRITERIA | | | |
| 1. **Allied Health Assistant working/will work in the following Allied Health area/s.** | ☐Occupational Therapy  ☐Physiotherapy  ☐Pharmacy  ☐Speech Pathology  ☐Radiography | ☐Podiatry  ☐Social work  ☐Dietetics  ☐Audiology  ☐Recreation  Therapy |  |
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| 1. **Is applicant a permanent employee of NSW Health?** | ☐ Yes  ☐ No  ☐ Is temporary or casual however has worked in LHD/SHN more than 12 months | | |
| 1. **Name of qualification that funding is requested.**   **If Cert IV Allied Health Assistance is selected please indicate your specialisation choice and your areas of interest for elective subject choices.** | ☐ **Cert IV Allied Health Assistance**  **Specialisation within Cert IV AHA:**  ☐ Nutrition and Dietetics  ☐ Physiotherapy  ☐ Occupational Therapy  ☐ Physiotherapy/Occupational Therapy  **Your areas of interest for elective subject choices:**  ☐ Aged care  ☐ Disability  ☐ Rehabilitation  ☐ Groupwork  ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Single units from Cert IV Allied Health Assistance – Gosford TAFE**  ☐ HLTAHA017 Assist with Social Work  ☐ CHCMHS001 Work with people with mental health issues  ☐ **Cert IV Hospital/Health Services Pharmacy support** | | |
| 1. **Is the nomination supported by the line manager?** | ☐ Yes  ☐ No | | |
| 1. **The LHD/SHN Allied Health Director or Director of Pharmacy is aware of the nomination?** | ☐ Yes  ☐ No | | |

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| SELECTION CRITERIA STATEMENTS |
| 1. **What do you hope to achieve personally from completion of the course?** |
| Word limit approx. 500 words |
| 1. **How will the skills and knowledge you gain from this training benefit your workplace?** |
| Word limit approx. 500 words |
| 1. **Explain the need for and relevance of this training with respect to your current or planned (future) work role.** |
| Word limit approx. 500 words |
| 1. **The responses within this Selection Criteria Form are written by the applicant in their own words.** |
| Signature of applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| LINE MANAGER ENDORSEMENT | |
| **Comment:** | |
| **Name:** |  |
| **Designation:** |  |
| **Email Address:** |  |
| **The Director of Allied Health or Director of Pharmacy has been made aware of the application:**  ☐ Yes | |
| **Signature:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** / /2020 |

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| APPLICANT DECLARATION | | |
| I, as the applicant, declare that the information I have provided in this application is, to the best of my knowledge, true and accurate. I confirm that I:   1. Have sought approval for completing this qualification from my line manager. 2. Have read and understand the *Allied Health Assistant Scholarship Program Terms and Conditions.* 3. Agree to fulfil the requirements set out in the *Allied Health Assistant Scholarship Program Terms and Conditions.* 4. Will notify HETI if the granted funding and the proposed training is not able to take place. | | |
| **Print and sign this document.** |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name** | **Signature** | **Date** |
| **Please print off application, obtain required signatures,  then scan and send to** [**HETI-Scholarships@health.nsw.gov.au**](mailto:HETI-Scholarships@health.nsw.gov.au) | | |