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| 2020 ALLIED HEALTH WORKPLACE LEARNING PROFESSIONAL DEVELOPMENT PROGRAM |
| **Application Form** |

Please complete this form and submit to your **Director of Allied Health** by **22 May 2020** to be considered.

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| Section A - TEAM DETAILS | | |
| **Local Health District / Specialty Health Network:** | |  |
| **Name/description of allied health team/group:** | |  |
| KEY CONTACT PERSON | | |
| **Name:** |  | |
| **Work Telephone:** |  | |
| **Work Email Address:** |  | |

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| Section B - WORKPLACE LEARNING (WPL) ACTIVITY DETAILS | | | | | | |
| **Name of Workplace Learning (WPL) activity:** | |  | | | | |
| **WPL theme** | | Clinical supervision  Communication  Counselling  Knowledge sharing eg. onsite symposium  Mental health  Non-clinical workplace skill eg. leadership, workplace culture, project management  Rehabilitation  Research  Specific clinical skill, includes all other clinical skills that are specific to certain disciplines or settings eg. casting, drug management or cancer treatment  Trauma  Other theme; or a sub theme related to above themes | | | | |
| **WPL amount requested, inclusive of GST- $** | |  | | | | |
| **Location where WPL will occur:**  *Eg. – Dietetics Dept, Smithvale Hospital* | |  | | | | |
| **Number of people involved in WPL activity:** | |  | | | | |
| **Does your team include any members that identify as either Aboriginal or Torres Strait Islander?** | | No  Yes 🡺 (if so how many?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Disciplines of people involved in WPL activity:** | Allied Health Assistant | | Art Therapy | | | Audiology |
| Aboriginal Health Worker/ Practitioner in allied health support role | | Counselling | | | Dietetics & Nutrition |
| Diversional Therapy | | Exercise Physiology | | | Genetic Counselling |
| Music Therapy | | Nuclear Medical Tech. | | | Occupational Therapy |
| Orthoptics | | Orthotics & Prosthetics | | | Pharmacy |
| Physiotherapy | | Play Therapy | | | Podiatry |
| Psychology | | Radiation Therapy | | | Radiography |
| Sexual Assault | | Social Work | | | Speech Pathology |
| Welfare | |  | | |  |
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| Medicine | | Nursing & Midwifery | | |  |
| Other (please specify) 🡺 | |  | | | |
| *\*If ‘No’, please explain the established working relationship between NSW Health and non NSW Health team/group including its influence on patient care / workplace practices:* | | | | | |
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| **If WPL activity involves an external presenter/ facilitator, have you attached a quote to this application?** | | Yes | | No – this application will be ineligible if quotation is not attached | Not applicable | |
| **Will WPL activities be completed by 30/06/2021?** | | Yes | | No | | |

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| Section C - COST CENTRE MANAGER CONTACT DETAILS | |
| **Name of cost centre manager:** |  |
| **Email address:** |  |
| **Telephone number:** |  |
| **Cost centre number** |  |

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| KEY CONTACT PERSON DECLARATION | | |
| I, as the Key Contact Person, declare that the information we have provided in this application is, to the best of my knowledge, true and accurate. In signing this application on behalf of the team, I confirm that we:   1. have sought approval for conducting this workplace learning activity from the line managers of all people included in this application 2. have support from the cost centre manager 3. have read the *2020 HETI Workplace Learning Professional Development Program* *Terms & Conditions* 4. are not aware of any related interest, pecuniary or non-pecuniary, that may create, appear to create or have potential to create, a conflict of interest. 5. will complete an evaluation of this activity on survey monkey before 31 July 2021 6. will nominate another Key Contact Person if I am no longer available to continue this responsibility e.g. no longer employed in NSW Health or change to new unrelated role | | |
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|  |  |  |
| **Name** | **Electronic signature** | **Date** |

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| Section D - WORKPLACE LEARNING (WPL) ACTIVITY DETAILS | |
| 1. **Name of the proposed Workplace Learning activity:** | |
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| 1. **Please provide a detailed description of the proposed workplace learning activity** (including; detailed plan and purpose of the activity. Clear information on name of education provider, audience, location, timeframes. Include a training outline where possible) *approx. 300 words* | |
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| 1. **Please describe how this activity meets your district or networks priorities or local criteria** | |
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| 1. **Please describe how this workplace learning activity will improve clinical / workplace practices or patient care.** *approx. 300 words* | |
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| 1. **Please describe how this workplace learning activity will link to current unmet needs for your team and workplace** | |
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| 1. **Please describe how this workplace learning activity will demonstrate value for money** eg. Benefitting as many AHPs/AHAs as possible | |
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| 1. **What does this training mean for Aboriginal and Torres Strait Islander people?** (Please consider cultural and social impact). For example, will training in this area have a positive impact on service delivery for Aboriginal and Torres Strait Islander people? <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_034.pdf>. | |
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| 1. **Please provide an overview of how you would evaluate this workplace learning activity** (including; purpose, evaluation focus questions, data sources, methods and dissemination) *approx. 300 words* | |
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| 1. **Please provide an itemised budget of how the grant funds would be spent** (quotations are compulsory eg. Trainer fee) | |
| **ITEM** | **ESTIMATED COST** |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
| **TOTAL COST – inclusive of GST** | **$** |