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| 2019 ALLIED HEALTH WORKPLACE LEARNING GRANT PROGRAM |
| **Application Form** |

Please complete this form and submit to your **Director of Allied Health** for consideration

**Once approved by the Director of Allied Health this form should be saved as a PDF and uploaded as part of the online submission, including a separate quote for this workplace learning activity**

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| Section A - TEAM DETAILS  |
| **Local Health District / Specialty Health Network:** |   |
| **If located in a Rural or Remote Setting, please indicate your Australian Standard Geographical Classification – Remoteness Area (ASGC-RA):** <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/ra-intro>  |  |
| **Name/description of allied health team/group:****\****Please note, only one application per team will be accepted and applications can only be received from NSW Health employees* |  |
| KEY CONTACT PERSON |
|  **Name:** |   |
| **Work Telephone:** |   |
| **Work Email Address:** |   |

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| Section B - WORKPLACE LEARNING (WPL) ACTIVITY DETAILS |
| **Name of Workplace Learning activity:** |   |
| **Workplace learning theme** | [ ]  Clinical supervision[ ]  Communication[ ]  Counselling[ ]  Knowledge sharing eg. Workplace shadowing or 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 sub theme for one of the above themes  |
| **Workplace learning grant amount requested , inclusive of GST- $** |   |
| **Location where WPL will take place:***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 | [ ]  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 |  |  |
|  |  |  |
| [ ]  Medicine | [ ]  Nursing & Midwifery |  |
| [ ]  Other (please specify) 🡺 |   |
| **Are all members of this team employees of NSW Health?** | [ ]  Yes | [ ]  No\* 🡺 % NSW Health Employees |
| *\*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:* |
|   |
| **Approx. % who are either allied health professionals or allied health assistants:** |  % |
| **If WPL activity involves an external presenter/ facilitator, is this person aware of and in agreement with this application?** | [ ]  Yes | [ ]  No – this application will be ineligible if the presenter is not aware of this application | [ ]  Not applicable |
| **Will WPL activities be completed by 30/06/2020?** | [ ]  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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| DIRECTOR OF ALLIED HEALTH ENDORSEMENT (from the district or network within which you work) |
| **Name:** |   |
| **Designation:** |   |
| **Email Address:** |   |
| **Telephone 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 support from the Allied Health Director
4. have read the *2019 HETI Workplace Learning Grant Program* *Terms & Conditions*
5. agree to fulfil the requirements set out in the *2019 HETI Workplace Learning Grant Program Terms & Conditions*
6. will reimburse the funding back to HETI if we are granted funding and the proposed workplace learning activity does not take place.
7. 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.
8. will immediately bring to the attention of the HETI allied health team any change in circumstances.
9. will complete an evaluation of this activity on survey monkey before 31 July 2020
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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 provide justification based on evidence of why this workplace learning activity is important for your team and how they will improve clinical / workplace practices or patient care outcomes** (including reference to evidenced based practice, literature, data and/or links to NSW Health documents).

 **Consider how the training would change current practice.** *approx. 500 words*  |
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| 1. **Please state three learning objectives for the proposed workplace learning activity.***Learning objectives should be specific and measureable and where appropriate, linked to the evaluation*
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| **i.** |   |
| **ii.** |   |
| **iii.** |   |
| 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. Medium and Long term evaluation plans, example evaluation survey or focus questions and/or sustainability considerations will support strength of applications compared to immediate plans only) *approx. 300 words*
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| 1. **Please describe why this training is value for money or cost effective**
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| 1. **Please provide a budget of how the grant funds would be spent** (including; specific information, compulsory quotation required)
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| **ITEM** | **ESTIMATED COST** |
|   | $  |
|   | $  |
|   | $  |
|   | $  |
| **TOTAL COST – inclusive of GST** | **$**  |
| If total cost exceeds $4,000 (or up to $4,500 if rural or up to $5,000 if remote), please indicate how additionalfunds will be accessed |   |