



# Education Funding

## APPLICATION FORM

Please email completed form to: [NRHF@SASKHEALTHAUTHORITY.CA](mailto:NRHF@SASKHEALTHAUTHORITY.CA)

### Applicant Information

Contact			
Address			
City		Postal Code	
Phone		Email	

### Employment Details

Facilities	<input type="checkbox"/> Nipawin Hospital <input type="checkbox"/> Nipawin Community Services <input type="checkbox"/> Pineview Lodge Nursing Home <input type="checkbox"/> Carrot River Health Centre <input type="checkbox"/> Arborfield Health Centre <input type="checkbox"/> Cumberland House Health Centre <input type="checkbox"/> Smeaton Health Centre <input type="checkbox"/> Third Party: _____		
Department(s)			
Occupation		Years of Service	
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual			

## Education/Course Information

Funding will not be given to primary education if it is a requirement of employment.

Course/Conference Name:			
Description			
Start Date		End Date:	
Is this education a requirement for your employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Explain How You See This Education Benefiting The Health Care You Provide.  
(improves patient outcomes, reduces travel, enhances skills, etc)

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## Summary of Expenses

All receipts must be attached: (applications less than \$50.00 are not accepted.)

Salary, books, manuals and other instruction material are not reimbursed

Expense	Amount	Form Of Payment	
		<input type="checkbox"/> Self	<input type="checkbox"/> SHA
Tuition	\$	<input type="checkbox"/> Self	<input type="checkbox"/> SHA
Accommodation: List names if shared.	\$	<input type="checkbox"/> Self	<input type="checkbox"/> SHA
Meals	\$	<input type="checkbox"/> Self	<input type="checkbox"/> SHA
Other (Please specify)	\$	<input type="checkbox"/> Self	<input type="checkbox"/> SHA
Travel (# of km's x SHA mileage Rate \$.6910)	\$		
<b>Total Request</b>	\$		

**\*Disbursements come from Saskatchewan Health Authority (SHA), and then billed to the Foundation. The Foundation does not provide disbursements directly to applicants. Please get in touch with SHA MyConnections for any questions or concerns you may have on reimbursement.**

## Applicant Signature

Applicant Name			
Signature of Applicant		Date	

## Application Approval Signature

If a supervisor signature is not available, please attach the email containing the approval.

Name of Supervisor		Position	
Signature of Supervisor		Date	

**\*\*NIPAWIN REGION HEALTH FOUNDATION USE ONLY\*\***

<b>Request is</b>	<input type="checkbox"/> Approved	<input type="checkbox"/> In Part	<input type="checkbox"/> Rejected
<b>Amount Approved:</b>		\$	

**COMMENTS:**

Approval Signature		Date	
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