TOOWOOMBA HOSPITAL FOUNDATION

SCHOLARSHIP

APPLICATION FORM

The Toowoomba Hospital Foundation provides funding for the provision of equipment, staff education, training and professional development, health and medical research and scholarships.

When completing this Application please refer to the *Scholarship* Guidelines.

Applicant Contact Details

Name:	
Position or Grade/Level:	
Workplace:	
Employee ID Number:	
Address:	
Phone:	
Email:	

Application Details

Tick the relevant category:	❑ Undergraduate Studies ❑ Post Graduate Studies ❑ Full-time study ❑ Part-time study
Proposed Award Course and Educational Institution:	
Expected duration of course:	

Describe benefit to health care delivery for the Toowoomba Hospital, Baillie Henderson Hospital or Mt Lofty Heights Nursing Home:

Please Note: *If these questions are not answered, your Application will not be progressed.*

1. Are any other funding options available to you (ie ROPP, SARAS, AO Training & Development)?
   ❑ Yes ❑ No

2. Have you applied for funding elsewhere? ❑ Yes ❑ No

   If yes, where have you applied: _____

   How much have you applied for: _____

   Were you successful in your application for other financial assistance? ❑ Yes ❑ No

3. Are you eligible for Professional Development Assistance under your Award/Certified Agreement with DDHHS? ❑ Yes ❑ No

4. If yes, how much do you receive $_____

5. Have you used this allowance and if so for what purpose? ❑ Yes ❑ No
   (Please detail expenditure below of PDA including dates & amounts)

Referees

Provide name and contract details below:

Referee 1:	Contact Details:
Referee 2:	Contact Details:

Costings **(Grants are to a maximum of $5,000)**

Actual Costs		**Amount Requested**	
Course Costs		Course Costs	
Course Materials		Course Materials	
Other costs		Other costs	
TOTAL		**TOTAL**	

Note: *Reimbursement of funds will be made to the Applicant upon successful completion of each study unit upon presentation of payment proof (ie tax invoice/receipt) and academic record.*

Applicant Declaration

I have read and understood the Guidelines for *Scholarship* funding and agree to abide by those conditions.

Name: …… Signature: …… Date: ……

Line Manager Declaration

This study is directly related to the current position held by the Applicant with the DDHHS.

Name: …… Signature: …… Date: ……

* Approval Signature required <u>prior</u> to sending Application to Toowoomba Hospital Foundation

Relevant Member of Darling Downs Hospital & Health Service Executive or relevant Hospital Service Manager.	❑ Endorsed ❑ Not Endorsed	Signed: **Print Name:**	Date:

Submission Contact Details

Toowoomba Hospital Foundation Office
41 Joyce Street
TOOWOOMBA QLD 4350
Fax: (07) 4616 6177
Tel: (07) 4616 6166

Email: THF@health.qld.gov.au
Website: www.toowoombahospitalfoundation.org.au

Office Use Only: Toowoomba Hospital Foundation Office Staff

Date received:	Signature