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**Health Workforce Directorate (HWD) Funds for Registered Nurses Postgraduate Education Southern**

**Application Form**

**The annual application round for 2023 HWD PGN funding is:**

**Thursday 1 September – Friday 30 September 2022**

Applications should be received no later than 5pm Friday 30 September

Late applications may not be considered in the initial funding allocation. All late applications will automatically be added to the waitlist and applicants notified if/when funding becomes available.

**Applications to be forwarded to:**

[HWDfunding@southerndhb.govt.nz](mailto:HWDfunding@southerndhb.govt.nz)

Postgraduate Nursing Education Office PDU (Otago), Box 20, Private Bag 1921, Dunedin 9054

**All sections must be complete, and the required documentation attached. Incomplete forms may be returned for completion or clarification and need to be returned by the closing date for consideration.**

**It is the responsibility of the RN completing this application to submit it to the above address.**

## Terms and Conditions of Funding

1. Submission of this application implies your consent to use your information for the purposes stated below (2) + (3)
2. The information collected is used to ascertain your eligibility for HWD Nursing Training Funds, and reporting requirements to HWD, as per the Ministry of Health Head Agreement. Your information will not be used for any other purposes and will be kept private and secure.
3. The Coordinator or Administrator for HWD funding may be required to contact your tertiary provider, line manager or Director of Nursing regarding your application and/or study/career plans.
4. You agree to adhere to the requirements of reporting and notification should you be successful in securing funding.
5. You understand that the funding is granted on the basis that the information you provide is true and accurate.
6. Funding does not transfer to a new employment setting/role unless this change has been authorised by the funding coordinator and supported by new line manager. Funding is also not transferrable for each semester without approval. Funding is not transferrable from year to year.
7. The Coordinator’s decision is final.
8. If funded, you agree to notify the Postgraduate Nursing Education Coordinator or Administrator of any changes that may impact on your funding including:
   * Changes to your name and/or contact details
   * Changes to your programme of study
   * Changes to your employment situation / line management/ FTE / Hourly Rate
   * Withdrawal from a Paper/ Qualification
   * Any changes to your eligibility to accept HWD Funding
9. If you choose to withdraw from your programme of study and therefore from HWD funding at any time after enrolment has been accepted, **you must also formally withdraw with your training provider.**   
   Failure to do so may result in you being liable for payment of fees and related costs.
10. A copy of your transcript must be sent to the Postgraduate Nursing Education Coordinator or Administrator on completion of each funded paper.

**I confirm that I have read and agree with the Terms and Conditions outlined above.**

**Print Name: Date:**

**Signature:**

**Reminder: All sections must be completed in this application, or application may be returned**

## Section One: Personal Details

**If completing by hand, please print clearly. Email will be the main form of contact.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Applicant last name |  | | | | | | |
| Applicant first name/s |  | | | | | | |
| If this name is not the one that appears on your APC, please provide name/s as per APC | | | | | | | |
| Name also known as |  | | | | | | |
| NCNZ Annual Practicing Number (APC)  **Please attach a copy of your APC profile information** | | | | Year of RN graduation | | | |
| Home Postal Address | Street number & name | | | | | | |
| Suburb | | City/town | | | | Post code |
| Phone Contact Details | Home | | | | Mobile | | |
| Work | | | | Work extn | | |
| Email  (Please tick beside preferred email contact) | Personal | | | | | | |
| Work | | | | | | |
| Date of Birth | | | | Gender Male / Female / Gender Diverse | | | |
| Residency Status | | | | | | | |
| NZ Citizen | | NZ Resident Visa | | | | | |
| Work Visa | | Australian Citizen / Permanent Resident | | | | | |
| NZ Permanent Resident Visa | | Other (please advise) | | | | | |
|  | | | | | | | |
| Ethnicity | | | | | | | |
| European | |  | | | |  | |
| Māori Iwi/Hapu (if applicable) | |  | | | | | |
| Pacific Islander | |  | | | |  | |
| Asian | |  | | | |  | |
| Other ethnicity (please advise) | |  | | | | | |
| If you have identified yourself as Māori or Pacific Islander, would you like further information on cultural mentorship / supervision? Yes  No | | | | | | | |

## Section Two: Employment Details

|  |  |  |
| --- | --- | --- |
| Current/supporting employer/s |  | |
| Position/Role |  | |
| Work area/ward |  | |
| Directorate (if applicable) |  | |
| Hourly pay rate $  **Must be completed - required to calculate release funding** | | FTE |
| Contract  Permanent  Fixed Term End of Fixed Term Contract Date / / | | |

### Employer Details (Applicant to complete)

|  |  |  |
| --- | --- | --- |
| Line manager |  | |
| Line manager title |  | |
| Line manager e-mail |  | |
| Line manager phone | Work extn | Mobile |
| Director of Nursing  (if applicable) |  | |

### Place of Employment

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dunedin Hospital | | Southland Hospital | | Wakari Hospital |
| Other (please advise) | | | | |
| Business Name |  | | | |
| Street number & name |  | | | |
| Suburb | | | City/town | |
| Postal Code | | | PO Box | |

## Section Three: Area of Practice

|  |  |  |
| --- | --- | --- |
| Acute/intensive care | Infection Prevention & Control | Palliative care |
| Addiction Services | Intellectually Disabled | Perioperative |
| Aged Care | Long Term Conditions | Policy & Management |
| Assessment & Rehabilitation | Māori Health | Primary Health Care - General |
| Cardiology | Medical | Radiology |
| Child Health | Mental Health Inpatient | Remote or Rural Areas |
| Community Mental Health | Neonatal Intensive Care | Respiratory |
| District Nursing | Nephrology/Renal | Sexual Health |
| Emergency/Trauma | Nursing Research | Surgical |
| Endocrinology | Obstetrics/Maternity | Urology |
| Gastroenterology | Occupational Health | Youth Health |
| Haematology | Oncology | Other, please advise |
| Health Education | Ophthalmology |  |
| High Dependency Unit | Orthopaedic |  |

## Section Four: Postgraduate Study History

|  |
| --- |
| Have you previously received HWD Funding for Postgraduate Study?  Yes  No  If yes, please state which year/s |
| Have you previously been declined from HWD Funding  Yes  No  If yes, please state which year/s |
| Have you previously withdrawn from HWD Funding  Yes  No  If yes, please state which year/s |

|  |  |  |  |
| --- | --- | --- | --- |
| **Completed Qualifications:** | | **Year** | **Tertiary Provider** |
| **Qualification** | **Name of Qualification** |  |  |
| **PG Certificate/s** |  |  |  |
|  |  |  |
| **PG Diploma/s** |  |  |  |
|  |  |  |
| **Masters** |  |  |  |
|  |  |  |

## Section Five: Proposed Qualification

|  |  |  |
| --- | --- | --- |
| The qualification you are enrolled or will be enrolling in | | |
| PG Certificate (60 pts) | PG Diploma (120 pts) | Masters (240 pts) **attach abstract for dissertation or thesis** |
| **Papers must be at Level 8 and be able to be credited towards a Nursing Council New Zealand (NCNZ) approved nursing programme.** | | |
| Tertiary provider where you are enrolled for your qualification  **\*It is important to indicate with a ✓ against the delivery site for each semester for travel funding allocation. If your study is being delivered in multiple locations, please indicate Sm1 or Sm2 alongside each delivery site.** | | |
| University of Otago Centre for Postgraduate Nursing Studies | | University of Otago |
| Southern Institute of Technology (SIT) | Eastern Institute of Technology (EIT) | Massey University |
| Auckland University of Technology (AUT) | The University of Auckland | Victoria University of Wellington |
| University of Canterbury | Whitireia Polytechnic | ARA Institute of Canterbury |
| Other (please specify location | |  |

|  |  |
| --- | --- |
| Location of Study |  |
| Study Delivered | Online  Blended Delivery |

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| --- | --- |
| **Current Qualification: List PG nursing papers complete & incomplete towards the qualification you are currently enrolled or will be enrolling in** | **Year Completed** |
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## Section Six: Proposed Course of Study for 2023

**It is the applicant’s responsibility to complete the enrolment process with the tertiary provider and must be done to accept HWD funding**

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| --- | --- | --- | --- |
| **Semester 1 / 2023** | | | |
| Course Number | Course Dates | Course Name (as it appears on the information sheet) | Points |
|  |  |  |  |
|  |  |  |  |
| **Semester 2 / 2023** | | | |
| Course Number | Course Dates | Course Name (as it appears on the information sheet) | Points |
|  |  |  |  |
|  |  |  |  |
| **Full Year 2023**  **\*Full Year indicates a paper that runs over both semesters – not two separate papers** | | | |
| Course Number | Course Dates | Course Name (as it appears on the information sheet) | Points |
|  |  |  |  |
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**Your expected timeframe for completion of the qualification enrolled in (i.e., PG Certificate, PG Diploma or Masters)**

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| --- | --- | --- | --- |
| Semester |  | Year |  |

## Section Seven: Travel Subsidy (Limited Funding is Available)

To be eligible to apply for a travel and accommodation subsidy, travel from your place of work to the training provider must be >100 km one way

Would you like to be considered for travel and accommodation funding? Yes  No

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| --- | --- |
| Semester One | Semester Two |

|  |  |
| --- | --- |
| Comments: |  |
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## Section Eight: Professional Development Plan

**Professional Development and Recognition Programme (PDRP)**

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| --- | --- | --- | --- | --- | --- | --- |
| PDRP Provider | Regional Programme | | Other | | Not Applicable | |
| Current PDRP Level | Level 2 | Level 3 | | Level 4 | | Not currently on PDRP |
| Performance Appraisal (PA) (within the last 18 months)  Date of **current** performance appraisal (PA) / / | | | | | | |

## Section Nine: Sources of Funding

Have you applied for or received any other funding or scholarship toward 2023 study? Yes No

If yes, Amount received/applied for $

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| Please provide details |  |
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## Section Ten: Career Plan/Future Pathways

**HWD require all funded trainees to have a current career plan.** HWD Career Plan template is attached to the end of this application. Please notify PGNE Office if you have submitted a career plan within the last 2 years and if it is still current, then you may not have to submit another one at this stage.

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| Please provide a brief explanation of your career plan e.g., professional development plan |
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**Indicate if you are completing RN Prescribing Papers**  PG Diploma  Masters

## Section Eleven: Any Further Comments

Please provide any further comments or information that may be relevant for your HWD Funding application

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## Section Twelve: Line Manager Agreement

I have reviewed and discussed this application with (applicant name)

The qualification is relevant to service goals/direction for the workforce/organisation

I have considered the implications of clinical coverage

I will negotiate a trainee release plan with the applicant to facilitate attendance for the compulsory requirements of this course, including days not covered by HWD funding

I have seen and discussed the career plan of the applicant

In signing this form, I fully support and endorse this application for funding

\*Note: If the applicant works in two areas, **both** Line Managers must support this application

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| --- | --- | --- | --- |
| Line Manager name |  | Signature |  |

Comments to support application

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Date

## Section Thirteen: Nurse Practitioner, RN Prescribing and Expanded Practice Pathways

Where applicable Director of Nursing (DoN) approval/support is required if you are completing papers/qualification that leads to Nurse Practitioner, RN Prescribing or expanded practice for registered nurses. Prior to submitting your application for HWD funding, applicants must arrange to meet with their DoN to discuss their application, study pathway and career plans.

|  |  |  |  |
| --- | --- | --- | --- |
| Director of Nursing name |  | Signature |  |

Comments to support application

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Date

## Section Fourteen: Checklist

**Before submitting your application, please ensure that the following is completed and attached**

**Fully Completed** Application Form

Copy of Annual Practicing Certificate

A copy of the paper/qualifications or course outline

Line Manager endorsement

Director of Nursing approval/support as relevant

Copy of Career Plan and/or abstract as relevant

Agree to Terms and Conditions of funding (see front page of application)

**Please note:** To ensure all applications are given an equal opportunity to secure HWD Funding to support postgraduate nursing education, **all** the information requested must be supplied. This is a requirement of Health Workforce Directorate (HWD), Ministry of Health and will only be released to HWD for reporting and auditing purposes and to meet the requirements of the Privacy Act 1993.

For further assistance contact:

Postgraduate Nursing Education District Office within the Practice Development Unit (PDU) Otago:

Email: [HWDfunding@southerndhb.govt.nz](mailto:HWDfunding@southerndhb.govt.nz)

**Jo Dobson**

Coordinator - Postgraduate Nursing Education

DDI: 03 470 9675 or internal extn 59675

**Kylie Legg**

Administrator - Postgraduate Nursing Education

DDI: 03 470 9673 or internal extn 59673

**Postal Address**

c/- Practice Development Unit (Otago)

PG Nursing Education Office

First Floor Fraser Building, Cumberland Street, Dunedin

Box 20, Dunedin Hospital

Private Bag 1921, Dunedin 9054

# HWD Career Plan (District)

|  |  |
| --- | --- |
| Name |  |
| Current Position |  |
| Employer |  |
| Date |  |

## Part One: Knowing Yourself

The first step in planning your career is evaluating and understanding your aspirations; strengths; interests; drivers and other influences. Please indicate which aspects of the planning process you have evaluated:

My key strengths

My technical skills

My work values

My key fields of interest

Briefly records these here if you wish (optional)

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For an objective assessment, seek guidance from others as well.

A discussion regarding your career aspirations, strengths and development needs during a performance review is regarded as a minimum. Informal discussions throughout the year with various people are encouraged.

Who have you discussed your career with?

Manager

Professional leader

Professional/clinical supervision

Educator

Tutor (at tertiary institution)

Mentor

Career development professional

Other (please state)

Through your self-assessment you may have identified particular skills or areas of knowledge you wish to develop. What are these?

**Development Opportunities:**

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## Part Two: Explore Possibilities

Research the development possibilities and career pathways that are open and attractive to you. Consider your self-assessment outcomes and future health workforce needs.

**Pathway Option 1**:

Prerequisites and requirements to achieve this option:

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**Pathway Option 2**:

Prerequisites and requirements to achieve this option:

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**Pathway Option 2**:

Prerequisites and requirements to achieve this option:

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## Part Three: Making Choices

Consider the suitability of each option and decide (with the assistance of the person you report to) which one is the best match to your aspirations and workforce needs. Before making the decision, consider also:

* What are the perceived barriers/obstacles and how can they be overcome
* Outside of work commitments
* The level of involvement required
* Which of my options responds best to my employer and workforce needs?

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Based on the choices you have made, and the development opportunities you have identified now write your goal(s). Aim to make each goal as specific as you can.

**Goal 1**:

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Required to achieve goal 1:

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**Goal 2**:

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Required to achieve goal 2:

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**Goal 3**:

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Required to achieve goal 3:

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## Part Four: Make it Happen

In order to achieve your goals you need to have an agreed course of action. You and your manager need to have a clear understanding of what steps you will be taking, the commitment needed by both you and your manager and relevant timeframes.

You are now ready to detail who has to do what to make things happen.

**Agreed course of action/action plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Start Date** | **Completion Date** | **Skill experience, knowledge to be gained** | **How will this be gained?**  (e.g. on the job experience, formal/informal seminars/courses, coaching/mentoring etc.) | **Provider**  (e.g. workplace educator, university, coach/mentor etc.) |
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**Assessing the effectiveness of the action plan**

Specify how to assess the extent to which the agreed course of action has achieved the stated goals

**Portability**

This career plan belongs to the employee/trainee. It provides the basis for ongoing career discussions within current and future employment and professional relationships. Any transfer of information to future employers or others requires the employee/trainee’s consent.

**Review Dates**

Progress on the agreed course of action will be reviewed on:

This career plan will be reviewed on:

**Manager/supervisor sign-off**

|  |  |
| --- | --- |
| Name | Title |
| Signature | Date |

**Employee/trainee sign-off**

|  |  |
| --- | --- |
| Name | Title |
| Signature | Date |