

## Clinical Training Agency (CTA) Tertiary Programme Application to Study Form - Primary

This form is used by Registered Nurses who are an employee in Primary Health Care e.g. Aged Care, Medical Centres and NGO etc.

**A. APPLICANT (Please print clearly)** All sections must be completed. All incomplete applications will be returned for completion.  
 (These can be re-sent but will only be considered if returned before the closing date)

Name:		DOB: __/__/____	Health Practitioner Registration No:		
Position Title:		Employer:			
Phone number(s): <small>Work/Home/Mobile</small>		Email:			
Full time/Part time Hours: <small>If part time specify contracted hours per fortnight or FTE, e.g. 72hrs or .9 FTE</small>		Work address:			
Iwi (if applicable)		Ethnicity:			
Is the name which appears on your Annual Practising Certificate (PC) the same as above?					YES <input type="checkbox"/> NO <input type="checkbox"/>
If no, what name is on the PC?					
Programme of Study: <input type="checkbox"/> Post Grad Cert, <input type="checkbox"/> Post Grad Diploma, <input type="checkbox"/> Masters, <input type="checkbox"/> Masters with Prescribing ( <i>Please tick box</i> )					
Educational/Tertiary Institution:					
Post Graduate Qualifications Already Gained:					
How many papers completed in current programme: Number <input type="checkbox"/> ( <i>Attach names of papers to back of application</i> )					
<b>PAPERS (for which CTA funding is being sought)</b>					
Code	Points	Title	Dates & Days	Contact hours eg:lecture online hours	Semester (specify A or B or both)
Will your qualification be completed in the next year?					YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you applied for or received any other funding or scholarship toward this study?					YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes give details:					
<b>APPLICANT AGREEMENT:</b>					
<ul style="list-style-type: none"> <li>I agree to trainee information being provided to CTA.</li> <li>I will write to the CTA Post Graduate Nurse Coordinator to advise of any changes in my enrolment.</li> <li>Except for extenuating circumstances (ie: circumstances and or reasons beyond my control), if I fail to complete the postgraduate paper I will reimburse the Waikato DHB the CTA funding received.</li> <li>I permit and authorise Waikato DHB to contact the tertiary institution I am studying at, or have studied at, to seek confirmation of my course completion and grade.</li> </ul>					
Applicants Signature: _____				Date: _____	
<small>Note: All information collected remains confidential and is covered with the Privacy Act 1993 (Principle 2 – source of personal information). The rationale for collection of this data is to meet the requirements within the CTA specifications and to provide them with accurate reports.</small>					
<b>EMPLOYER SUPPORT:</b>					
<ul style="list-style-type: none"> <li>I have reviewed and discussed the contents of this form with the applicant.</li> <li>I have considered the implications of clinical coverage should the applicant be successful with this application.</li> <li>I have identified the clinical release time I have provided to the applicant</li> <li>By signing this form I fully support and endorse this application for funding.</li> </ul>					
Employers Name: _____				Date: _____	
Employers Signature: _____					
<b>CHECKLIST</b> Before sending this Form please check that you have done the following:					
<input type="checkbox"/> Answered all questions and signed the Form ( <b>Remember failing to complete the form will be detrimental to your application</b> )					
<input type="checkbox"/> My Manager/Employer has signed the Form					

Please forward this information to the above address.