Postgraduate Nurse Coordinator
Percival Flats
Waikato Hospital
Private Bag 3200
Hamilton

Health Workforce New Zealand (HWNZ) (formerly called 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): Work/Home/Mobile		Email:
Full time/Part time Hours: If part time specify contracted hours per fortnight or FTE, e.g. 72hrs or .9 FTE		Work address:
Iwi (if applicable)		Ethnicity:

If you have identified yourself as Maori / Pacific Islander would you like further information on cultural mentoring / supervision? YES ☐ NO ☐

Is the name which appears on your Annual Practising Certificate (PC) the same as above? YES ☐ NO ☐

If no, what name is on the PC?

Programme of Study: ☐ Post Grad Cert, ☐ Post Grad Diploma, ☐ Masters, ☐ Masters with Prescribing (***Please tick box)***

Educational/Tertiary Institution:

Post Graduate Qualifications Already Gained:

How many papers completed in current programme**:** Number ☐ (***Attach names of papers to back of application***)

PAPERS (for which HWNZ funding is being sought)

Code	Points	Title	Dates & Days	Contact hours eg:lecture online hours	Semester (specify A or B or both)

Will you be claiming travel for this paper? *(To be eligible you have to travel 100kms or more to your tertiary provider)* YES ☐ NO ☐

In which year will your present qualification be completed? ________________

Have you applied for or received any other funding or scholarship toward this study? YES ☐ NO ☐

If yes give details:

APPLICANT AGREEMENT:

- I agree to trainee information being provided to HWNZ.
- I will write to the Post Graduate Nurse Coordinator to advise of any changes in my enrolment.
- 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.

Applicants Signature:____**Date:**____________

Note: All information collected remains confidential and is covered with the Privacy Act 1993 (Principle 2 – source of personal information). The rational for collection of this data is to meet the requirements within the HWNZ specifications and to provide them with accurate reports.

EMPLOYER SUPPORT:

- I have reviewed and discussed the contents of this form with the applicant.
- I have considered the implications of clinical coverage should the applicant be successful with this application.
- I have identified the clinical release time I have provided to the applicant.
- By signing this form I fully support and endorse this application for funding.

Employers Name:____**Date:**___________

Employers Signature:____

CHECKLIST Before sending this Form please check that you have done the following:

☐ Answered all questions and signed the Form (**Remember failing to complete the form will be detrimental to your application**)

☐ My Manager/Employer has signed the Form

Please forward this information to the above address.