Revised January 2017

Kay Stafford Fund
TRENTON MEMORIAL HOSPITAL FOUNDATION

2017
Staff Education Application Guide

The following criteria must be met to be considered for any grants:

1. A minimum of 50% of your work time **must** be devoted to programs/services at QHC Trenton Memorial and this **must** be supported with a letter from your direct supervisor.
2. Applications must be **made annually for multi-year** programs.
3. Applications should only be completed when funding is not available from other sources within Quinte Health Care and your respective union affiliations.
4. The application must be completed in full; any incomplete sections will disqualify the application.
5. Supporting documentation such as course description, cost, registration etc. **must** be attached.
6. Grants will **not** fund: meals, overnight accommodation or travel.
7. Grants will consider funding up to 50% of tuition costs only for current fiscal year.
8. Grants can only be submitted following completion of course.

The monetary allocations will vary depending upon the investment income available from the Kay Stafford Fund for staff education as well as the number of applicants at the time of consideration and overall dollars committed during the year.

The Trenton Memorial Hospital Foundation will do its best to review applications on a monthly basis, time permitting. They must be received before the 15th of the month for inclusion.

Upon submission of your application, **please do not contact** the Foundation office to check on your application. Please be patient and a response will be sent directly to you upon review.

NEW:
All grants will be awarded once per year, at the annual Phil Panelas BBQ. For 2017, this will be on Thursday June 22, 2017.

KAY STAFFORD STAFF EDUCATION APPLICATION

(A) APPLICATION FORM

1. Applicant Name: _____
   Current department or unit:_____ TMH Extension_____
   Current position _____Manager: _____ext. _____
   Are you currently: Full time/Part Time/Casual
   Home Address: _____
   City/Town: _____ Postal Code: _____
   Tel Number: _____ E-mail: _____

2. I have been employed at QHC Trenton Memorial site since: _____

3. Is this for practice standard or certification that you must have for Your profession or work area? Yes___ No ___

4. How will this course(s) enhance the care you provide to our patients? Please check the MOST significant for you. (**Check only one)**

   ☐ Improves my quality of care for patients
   ☐ Increases my specialty/professional skills
   ☐ Improves my opportunity for advancement at QHC
   ☐ Increases my ability to participate in policy and decision-making
   ☐ Enhances my ability to move into another clinical area
   ☐ Enhances my ability to fill an alternative available position
   ☐ Other: _____

(B) COST OF COURSE/PROGRAM

Total Registration/Tuition Cost of Program:	**$_____**
Total Cost you are Funding yourself:	**$_____**
(including Textbooks, Travel, Meals, Accomodation etc.)	
Total Amount recovered from other source **s:	**$_____**
(Union, QHC, etc.)	
Amount being Requested from Kay Stafford Fund:	**$_____**

**If you have you applied elsewhere for funding?
If so, please indicate to whom you applied, when and the amount granted:
_____
_____

I certify that the information above is truthful and accurate to the best of my abilities.

Signature of Applicant**:** _____ Date: _____

Please Initial

- ❑ (i) I certify that the information provided above is true.
- ❑ (ii) I understand that any false or incomplete information submitted in support of my application may invalidate my application.
- ❑ (iii) Should my application be accepted, I agree to the release of my name and photo for publication purposes by the Trenton Memorial Hospital Foundation.

For TMH Foundation Office Use Only

Received by: _____ Receipt Date: __/__/__
Review Date: __/__/__

Grant Application: Accepted ____ Declined ____

If Granted: Total Amount: $_____ Terms:_____

If Declined – Reason: Incomplete ☐
Insufficient KS Funds ☐
Other ☐

Type of Education	Course Name	Educational Facility	Start Date (mm/dd/yy)	Completion Date (mm/dd/yy)	Tuition
☐ Clinical Specialty ☐ RN /RPN ☐ Degree ☐ Certification ☐ Other					
☐ Clinical Specialty ☐ RN/RPN ☐ Degree ☐ Certification ☐ Other					