**Health Workforce New Zealand (HWNZ)**

Postgraduate Coordinator

Percival Flats

Waikato Hospital

Private Bag 3200

Hamilton

**Tertiary Programme Application to Study Form – Non DHB**

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

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| 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) A Career & Development Plan must be completed and attached to this application.* | | | | | | | | | | | |
| Name: | | | | | | | Male  Female | | | | |
| Health Practitioner Registration No: | | | | | | | Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | | | | |
| 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** | | | | | | | **Postal address:** | | | | |
| **How long have you been a registered nurse:  2yrs,  3-4yrs,  5+yrs, (*Please tick box)*** | | | | | | | | | | | |
| 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, **(*Please tick box)*** | | | | | | | | | | | |
| **Qualification level**: List completed papers within each qualification level that builds towards your current qualification (e.g. Postgraduate certificate, diploma completed) | | | | | | | | | | | |
| Qualification | | Year | Paper number/Code | Name of paper | | | | | Paper credit value | | Grade |
| Postgraduate Certificate | |  |  |  | | | | |  | |  |
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| Postgraduate Diploma | |  |  |  | | | | |  | |  |
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| Postgraduate Masters | |  |  |  | | | | |  | |  |
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| **Indicate if completing prescribing papers** Postgraduate diploma prescribing  Masters prescribing | | | | | | | | | | | |
| Write down your student ID (if you have one) and the tertiary provider you will be studying through.  Student ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of tertiary provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **2021 Paper enrolments:** List papers you are planning to enrol in for 2021 (all semesters) | | | | | | | | | | | |
| Paper Code | Paper name | | | | Semester you wish to study in | Paper point value | | Where your course is being run | | Study days per course | |
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| Further applicant details | | | | | | | | | | | |
| Ethnicity: Please tick one of the following  New Zealand European  Other European  New Zealand Maori  Samoan  Cook Island Maori  Tongan  Niuean  Tokelauan  Fijian  Other Pacific groups  Southeast Asian  Chinese  Indian  Other Asian  Middle Eastern  Latin American/Hispanic  African or cultural group of African origin  Other ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Iwi (if applicable) | | | | | | | | | | | |
| If you have identified yourself as Maori / Pacific Islander additional support is offered and the Nurse Coordinator Cultural Support will contact you regarding this. | | | | | | | | | | | |
| Will you be claiming travel/accommodation 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 Administrator 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 rationale 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. * I have seen the applicants Career Development Plan and attached it to this form. * By signing this form I fully support and endorse this application for funding.   **Employers Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_  **Employers Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Employers Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Please tick one of the following:  Pinnacle ……………………………………………………………………  Maori Provider  Hauraki PHO………………………………………………………………  Maori Provider  Independent Practice…………………………………………………….  Maori Provider  National Hauora Coalition  Aged Care  Hospice  Home Base d Service  Other | | | | | | | | | | | |
| **CHECKLIST** Before sendingthis form please check that you have done the following:  Answered all questions and signed the Form (**Remember failing to correctly complete the form will be detrimental to your application**)  Attached your Career Development Plan  My Manager/Employer has signed the Form | | | | | | | | | | | |

Please forward this information to the above address.

The career planning cycle involves four steps, italicised below: *knowing yourself, explore possibilities, make choices, make it happen.* Refer to the Health Workforce New Zealand website for further information <http://www.healthworkforce.govt.nz/health-careers/career-planning/nursing-or-midwifery/nurses-four-step-career-planning-process>

This career and development plan has been based on the Waikato DHB Career and Development Plan for nurses.

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| **Employee:** *knowing yourself*assessment completed if required by the employee. Optional to list strengths, skills, values and interests in the goal below. |
| **Employee and manager/ clinician**. Before documenting the Career and Development Plan the employee and manager/ clinician *explore possibilities*and*make choices***.** Discuss perceived barriers, work life balance, level of involvement/ commitment, and other considerations that may affect the goal or plan. |

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| **Career Development Plan:** *make it happen* | | |
| **Long term goal**  *(write career development goal here)*  Support and leave to meet any objective in the plan requires agreement and authorisation by the line manager. | **How will I achieve my career development goal?** Objectives can include face to face or ecourses, on the job experience, coaching or mentoring. | Objectives met, and/ or review needed |
| **Short term (6-12 months)** | |
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| **Medium term (objective specifies the time line)** | |
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| **Longer term (objective specifies the time line)** | |
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Name: Position: Signature: Date:

Manager: Organisation: Signature: Date: