



HEALTH EDUCATION ENDOWMENT FUND APPLICATION

Thank You to our Donors for making these grants possible.

Health Education Endowment Fund	July	☐
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1. APPLICANT to complete SECTIONS A to E and send to Manager, Director or Executive Director to complete SECTION F.
2. MANAGER or DIRECTOR to complete SECTION F, approve and submit to RMH Foundation.

A. APPLICANT INFORMATION *(Please Complete All Fields)*

Last Name:	First Name:
Employee Number:	Position:
Department/Unit:	Health Authority:
Work Telephone:	Cell Phone:
Email address:	
Home Mailing Address:	
City:	Postal Code:

B. ELIGIBILITY

Health Education Endowment Fund: *you have worked a minimum of 100 hours at RMH MRPM Health Services, and expect to continue to work at RMH MRPM Health Services for at least a period of 18-24 months and are staff that directly serve patients/clients.*

Yes ☐ No ☐ *If no, you are ineligible to apply.*

Please note your current position:

Please note your current status; i.e. FT, PT, Casual

C. PURPOSE & DETAILS OF COURSE/PROGRAM *(Be specific and attach fee schedule)*

***Please note: Fund are not available for professional certifications that are a requirement for your position.**

For what purpose are you seeking education funds?

Conference/Workshop/Seminar (Check One): *Please be specific and attach fee schedule*

- ☐ Conference Registration
☐ Workshop
☐ Seminar

Conference/Workshop/Seminar Title:	
Name of Organization providing course:	
Course Location:	

Certificate or Degree Program (Check One): *Please be specific and attach fee schedule*

- ☐ Prerequisites for course certification
☐ Diploma Program – Specific diploma working towards:
☐ Undergraduate Degree Program – Specific degree working towards:

Program Name:	
Name of School/University:	
Name of Course(s):	
How many months/years is the certification or degree program?	
Start and end date of course(s) being applied for at this time:	
Course Location:	

D. COST & FUNDING INFORMATION

What is the registration cost of the course(s) you are applying for? **Registration Cost: \$**
Books, examination/recertification fees, travel, accommodation or lost wages are NOT eligible.

Have you applied for or received education funding from the RMH Foundation previously?

Yes ☐ No ☐

If yes, year(s) that you received funding:

Have you applied for (or received) any other education funding/sponsorship for this program/course/conference from your manager or other available education funds (e.g. Registered Nurses Foundation of BC)? **No ☐ Yes ☐ (Please explain)**

How much funding do you expect to receive from other sources? \$

E. BENEFITS OF COURSE/PROGRAM

How will this course, conference, workshop benefit you professionally?

How does this benefit the organization either directly or indirectly?

By signing below, you are verifying that all conditions have been met, the information is true and accurate to the best of your knowledge and compliance with any applicable FH policies has been met.

I have read the criteria for the application and agree to meet those criteria and to repay the education funds to the RMH Foundation if I leave the Health Authority within one year of receiving the funds.

Applicant Signature: _____ Date: _____
Original Signature Required

Forward the electronic copy to your Manager for completion, you will both need to sign the printed copy. Original signature required.

For your convenience, there is a Checklist for the Application at the end of the document to ensure that you have completed everything required for the Selection Committee.

F. MANAGER, DIRECTOR or EXECUTIVE DIRECTOR to complete. Submit to RMHF upon completion. Ensure original signatures are on the printed copy to be submitted.

**Please note: There must be no operational financial impact/cost to the Health Authority; i.e. backfill, course costs, travel costs etc.*

Will this staff person require any back fill? No ☐ Yes ☐ Please explain:

How will this conference/workshop benefit this staff person in the work they are already doing or in the work they might do in the future?

How will this conference/workshop benefit your program and Ridge Meadows Hospital or MR/PM Health Services?

Explain how this conference/workshop supports education/professional development and not operational use?

Have you exhausted other available funding? No ☐ Yes ☐ Please explain:

Section F (Continued)

I confirm that I have reviewed this application and confirm that there is no cost incurred by the Health Authority for this course; i.e. no backfill required, no shared course costs, no travel costs etc.

By approving this application I agree to put the employee's Expense Report through my cost centre. Finance will then invoice the Foundation for all allowable expenses and my cost centre will be reimbursed. My cost centre will NOT be reimbursed for expenses that the committee does not allow. The approval letter will list allowed/disallowed expenses.

For further information, please contact info@rmhfoundation.com

Manager Name:

Department/Program:

Telephone:

Email:

Cell:

Health Authority:

Manager Signature:

Original Signature Required

Date:

***Upon completion of Section F, print the completed application, the employee and the Manager sign and submit the original application to:**

RMH Foundation located in the Main Lobby, RMH
11666 Laity Street, Maple Ridge, BC V2X 5A3.

Foundation Use Only:

Date Application Received:	
Date Application Reviewed:	
Approved:	Yes ☐ No ☐
Date Decision Letter Sent:	



**RIDGE MEADOWS
HOSPITAL FOUNDATION**
SUPPORTING THE BEST IN HEALTH

CHECKLIST FOR APPLICATION:

For Applicant – All sections must be completed in full

- ☐ SECTION A: Applicant Information
- ☐ SECTION B: Eligibility
- ☐ SECTION C: Purpose & Details of Course/Program
- ☐ SECTION D: Cost & Funding Information
- ☐ SECTION E: Benefits of Course/Program
- ☐ Forwarded electronic copy to Manager
- ☐ SECTION F: Manager section
- ☐ Printed copy of application
- ☐ Original signatures of Applicant
- ☐ Original signature of Manager
- ☐ Attach all course information and costs