SKILLS ENRICHMENT SCHOLARSHIP PROGRAM
APPLICATION COMPLETION INSTRUCTIONS

Please complete this application LEGIBLY. Unreadable applications will be rejected.

Applicant Information: (Section A)
Complete all sections of "personal" information as indicated.
Notes:
As S.E.S.P. support payments are taxable, the Applicant's Social Insurance Number (SIN) is mandatory information and applications will be rejected if it is not included.
Through the course of your studies, the Foundation will need to communicate with you at different times, and we would therefore request that you advise us in writing of any change(s) to your name and/or contact information

Educational Background: (Section B)
Identify post-secondary education completed to date – starting with the most recent designation received.
If you are currently enrolled in a program please indicate "ongoing" in the "Certificate/Designation Achieved" line and include the anticipated "Conclusion Date". (Add a page for additional information if necessary)
"Other Courses/Training" – include information applicable to your career in healthcare.

Career Background: (Section C)
Whether you are currently employed in the "healthcare industry" or not, list your current and past employment history – beginning with the most recent.
If you are employed in the "healthcare industry" and are working in more than one facility and/or department, list them all. (Add a page for additional information if necessary)

Program/Courses/Classes: (Section D)
On the first line, please identify the Certificate Program or Degree Program that you are presently enrolled and/or will be enrolling in.
Indicate the "Start Date and End (Graduation) Date" of the Program.
Example: if it is a 2 year program – starting in September 2013 – you would indicate Sept 1/13 as the "Start Date" and June 2015 as the "End Date".
On subsequent lines indicate the courses and/or classes that will begin within the next six month period (semester) after the submission deadline date.
Note: refer to "Eligibility" requirements on the "Overview" page for additional clarification.
If a program extends beyond one semester, you will be required to submit new applications for each semester of your studies. The S.E.S.P. is designed to support costs on a "per class per semester" basis. Call the Foundation office for clarification if required.

Expenses: (Section E)
The S.E.S.P. is designed to support the costs of Tuition and Books related to the courses/classes being taken during the semester relative to this S.E.S.P. session as outlined above.
All requests for financial assistance must be supported by documentation confirming the estimated costs and all costs must be related to Tuition and/or Books.
There are some "Other" allowable costs but they must relate to the courses being taken and in the semester being reviewed.
The Program DOES NOT support travel or living costs while the Applicant is studying.
Examples:
a) Exam Costs relative to the classes being taken are eligible for support however the travel costs associated with attending a specified examination site are not eligible.
b) The cost of training materials (books; notes etc.) are eligible for support however any specialized equipment; tools; clothing; shoes etc. that must be purchased relative to the program and/or subsequent employment are not eligible for support.
Any application that is received that does not include sufficient information/documentation to confirm the estimate of costs will be rejected.

Other Funding: (Section F)
The Skills Enrichment Scholarship Program is intended to serve as the "last resort" source of funding available to Healthcare Providers wanted to expand or obtain skills relative to providing healthcare.
To have your application eligible for consideration, you must have first applied to other sources for financial assistance, including your employer.
List these other sources; the amounts you have applied for and the amount of assistance you are expecting from these other sources.
If your applications for other support have been declined or you are not eligible to apply for support under the programs, include documentation/comments outlining why your requests for support were declined.
Note: It is our understanding there are funds available from a variety of sources to support educational requests. As the Foundation intends to be the "last resort" it is the Applicant's responsibility to demonstrate on their application for assistance, why the Foundation's support is required.
For S.E.S.P. application purposes "Other sources of funding" include but are not limited to the following:

> Cypress Health Region	> Saskatchewan Health	> SAHA	> Govt. of Saskatchewan
> HSAS	> SEIU Canada	> SIAST	> U of S
> U of R	> Scholarships Canada	> Abbott Education Foundation Inc.	

Note: If at the time of S.E.S.P. application, the Applicant is uncertain as to the status of a request for "other funding", the applicant must advise the Foundation if this application is ultimately successful and The Foundation reserves the right to adjust S.E.S.P. payments by the amount of "other" payments.

Benefit of Program/Course/Classes & Declaration: (Section G)
Use this section to explain to our Committee your specific objective(s) relative to these classes/courses.
Describe the program and where you are in the program (example) 4 year Degree program – now entering year 2.
Provide sufficient details to allow our Committee to understand what the benefits will be to you and how you will be able to better serve your clients.
Carefully read the declaration, sign and date the completed application.
Note: Errors and/or misrepresentation on this application will cause this application and potentially, future requests, to be deemed as "ineligible" for support.

To Be Completed by Department Head (for CHR employees only): (Section H)
Department Head refers to the management person responsible for the area being impacted by your training. (This would normally be the person who is responsible for your employment evaluations.)
Ensure your Manager completes section and signs and dates the application. (If this information is not provided, your application will be deemed to be incomplete and <u>will not</u> be considered for funding)

SUBMIT COMPLETED APPLICATION TO:
Dr. Noble Irwin Regional Healthcare Foundation Inc.
Attention: SESP
2051 Saskatchewan Drive
Swift Current,
SK S9H 0X6

SKILLS ENRICHMENT SCHOLARSHIP PROGRAM APPLICATION FORM

(Indicate whether Full Time or Part Time Student)

REGISTRATION/TUITION & BOOKS/MATERIALS APPLICATION

Read the guideline pages attached before and while filling out your application.
Incomplete, incorrectly completed applications will not be considered for funding.
If you have any questions about this application form, contact the Foundation office at (306) 778-3314.

A. APPLICANT INFORMATION:

Name: _____
Last Name First Name Initial

Address: _____
Mailing Address Town/City Province Postal Code

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____S.I.N._____

B. EDUCATIONAL BACKGROUND:

School/Institution/Organization: _____

Program: _____

Certificate / Designation Achieved: _____

Year Studies Were Completed or Discontinued: _____

School/Institution/Organization: _____

Program: _____

Certificate / Designation Achieved: _____

Year Studies Were Completed or Discontinued: _____

School/Institution/Organization: _____

Program: _____

Certificate / Designation Achieved: _____

Year Studies Were Completed or Discontinued: _____

Other Courses or Training Completed:

_____
_____
_____
_____
_____

C. CAREER BACKGROUND:

Employer: _____

Department: _____ Facility: _____

Date Employment Commenced: _____

Supervisor/Manager's Name: _____Phone Number: _____

Employer: _____

Department: _____ Facility: _____

Date Employment Commenced: _____

Supervisor/Manager's Name: _____Phone Number: _____

Employer: _____

Department: _____ Facility: _____

Date Employment Commenced: _____

Supervisor/Manager's Name: _____Phone Number: _____

D. PROGRAM/ COURSE/ CLASSES to be taken (this semester): (Day/Month/Year) (Day/Month/Year)

Program Name	Certificate/Designation (upon completion)	Start Date	End Date
Course/Class		Start Date	End Date
Course/Class		Start Date	End Date
Course/Class		Start Date	End Date
Course/Class		Start Date	End Date
Course/Class		Start Date	End Date
Course/Class		Start Date	End Date
Course/Class		Start Date	End Date

E. EXPENSES (Per class – This semester):

Tuition/Registration: (attach documentation to confirm) $ _____
Materials/Books: (attach documentation to confirm) $ _____
Other: (attach documentation to confirm) $ _____
TOTAL: $
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F. OTHER FUNDING (attach documentation/details relative to support received or support declined):

_____Successful? (Y/N) _____
Source Amount Applied For Amount Received

_____Successful? (Y/N) _____
Source Amount Applied For Amount Received

_____Successful? (Y/N) _____
Source Amount Applied For Amount Received

_____Successful? (Y/N) _____
Source Amount Applied For Amount Received

G. BENEFIT OF PROGRAM/ COURSE/ CLASSES:

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- I certify that the aforementioned information is true and correct.
- I hereby authorize the Dr. Noble Irwin Regional Healthcare Foundation Inc. to validate any of the information related to this application.
- If I am approved for a Skills Enrichment Scholarship, I hereby give my permission to the Dr. Noble Irwin Regional Healthcare Foundation Inc. to publish my name, place of residence & employment and the name of the program/course related to this application in written documents, publications or other type of media for purposes identifying approved applicants of the Skills Enrichment Scholarship Program, to be used to promote the Foundation and the Program.

Signature of Applicant: _____ Date: _____

H. TO BE COMPLETED BY DEPARTMENT HEAD

Please note whether or not you would recommend this training, your reasons, and how the training relates to the priorities and operations of your facility/department. Please print and be specific.

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Dept. Head Signature: _____ Date: _____

Printed Name: _____ Department: _____