



## HEALTH CARE EDUCATION STAFF BURSARY FUND

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### DESCRIPTION & ELIGIBILITY

The administration for the distribution of funds is the responsibility of the **Olds HealthCare Fundraising Committee**. Olds Healthcare Fundraising Committee is a Local Not-For-Profit committee made up of citizens of Olds and area, with support from employees within the healthcare system. **With a Vision of “ Being Leaders in inspiring generosity to enhance health care in our community.”**

1. All employees who have completed the probationary period requirement with any AHS operated health facility in Olds and PCN in Olds are eligible to apply.  
**(PCN employees must work within the Town of Olds)**
2. Any job-related program/workshop that supports professional development/employee wellness or personal growth will be considered for funding.
3. Before funding is considered, applicants must have checked with their own department manager to see if the program can be funded through their department education budget and if funding is not available, a note from the department manager stating that funds are not available must accompany the application form.
4. Any full-time staff members, as stated in No. 1 above, are eligible for funding to a maximum of \$500.00.
5. Part-time & casual staff are eligible for a maximum of \$ 300.00
6. Train the trainer instructor courses will be funded to a maximum of \$300.00
7. Funding is for tuition only.
8. Funding will be approved prior to attending the program, after submitting a completed application form. Receipt of funds will follow after completion of the said program applied for, and with proof of attendance. Only the amount of funds requested will be paid out, up to the eligible maximum.
9. Applications will be received and reviewed by the Olds HealthCare Fundraising Committee. Applications must be dropped off to the Olds Hospital and Care Center Site Manager.

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**APPLICATIONS ARE ACCEPTED, starting March 1st each year and will continue until available funds are expended in the calendar year for which the request was made.**

# HEALTH CARE EDUCATION STAFF BURSARY FUND



OLDS HEALTH CARE  
**FUNDRAISING**  
COMMITTEE

## BURSARY APPLICATION FORM

DATE SUBMITTED: \_\_\_\_\_

MM/DD/YYYY

NAME OF APPLICANT: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EMAIL \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

APT

STREET NUMBER

TOWN

PROV

POSTAL CODE

COMPLETED PROBATION PERIOD WITH AHS FACILITY IN OLDS  YES  NO

EMPLOYMENT STATUS :  PART-TIME  FULL-TIME

START DATE OF PROGRAM: \_\_\_\_\_ DATE COMPLETED \_\_\_\_\_

TUITION FEE/ COST OF THE PROGRAM: \_\_\_\_\_

*Cost of travel, hotel accommodation or airfare are ineligible for funding*

NAME OF PROGRAM/WORKSHOP (JOB RELATED) WANTING TO APPLY FOR:

*(employees must work within the town of Olds to apply)*

Has funding been sought elsewhere (e.g union)  YES  NO

If yes, please state where: \_\_\_\_\_

**Applications must be dropped off to: Olds Hospital and Care Center Site Manager**

***Manager's Approval as having been reviewed for submission:***

\_\_\_\_\_  
**Manager's Name (print)**

\_\_\_\_\_  
**Manager's Signature**

*FOR OFFICE USE ONLY*

APPROVED  YES  NO

**BURSARY AMOUNT TO BE PAID:** \_\_\_\_\_