

Medical Professional Development Program

Application Form 2018-2019

Important Information

- This application form should be read in conjunction with the Victorian Department of Health and Human Services (the department) Medical Professional Development Subsidy program guidelines and the Rural Workforce Agency Victoria (RWAV) guidelines.
- Information that you provide on this application form and in the additional requested documents is the only information that will be considered in the selection and ranking process.
- This application form should be completed and lodged with RWAV within 60 days of the training, or by the end of the financial year, whichever is sooner.
- It is very important that you make sure you have provided all the relevant information for each section on this form. Incomplete applications will not be considered.
- The number of scholarships and grants awarded is subject to available funds and evenly distribution across Victoria.
- For the purposes of taxation, money from the scholarship scheme may be considered as income. Please seek advice from your accountant.

Application Form Instructions

- Read this application form and the separate guidelines carefully before filling in the application form.
- Answer all questions on this application form relevant to your application.
- The application is to be completed electronically and saving the form as a PDF and submitting via e-mail to grants@rwav.com.au.
- All supporting documentation is to be scanned and attached to the email with the application form.
- Please do not send originals of any supporting documentation requested, as these documents will not be returned to you.
- Supporting documentation must be supplied with this application. This include:
 - Copies of original receipts detailing the general practice's name, the name of the training event, provider, dates, and amounts paid;
 - Proof of completion of conference/event attendance;
 - Copies of original receipts for accommodation must stipulate name of registered commercial provider, dates and total amount paid; and
 - Copies of original receipts for childcare.

Timelines:

Applications can be received up until 5:00pm 30 June 2019; payment will be made once all completed documentation has been received.

Applicant Details

Title

First Given Name

Second Given Name

Surname

Gender

Date of Birth

Daytime contact number

Email Address (personal)

Are you a GP working in a Rural General Practice? Yes No

- If yes, are you providing medical services to your local hospital as a Visiting Medical Officer (VMO)? Yes No

Are you a Rural Stream registrar undertaking GP terms in RA 2-5? Yes No

- If yes, is this CPD activity funded through vocational training? Yes No

Are you a rural medical intern completing a minimum of thirteen weeks in a rural community placement? Yes No

Address Details -

Postal address

City

State

Postcode

Street address (if different to above)

Did you reside at this address in 2017/18? Yes No

If no, in what town/suburb did you reside

Employment Details

Name of Practice/Health Service:

Street

City

State

Postcode

Telephone (work)

Email Address (work)

Period of Employment

Education Details:

Name of event:

Location of event:

Date(s) & Times:

Topic/Discipline:

Expenditure – (Copy of original tax invoice/receipts required as evidence)

Procedural course registration fee (70 per cent reimbursement *must also submit **Appendix One**)

Non-Procedural course/conference registration fee (50 per cent reimbursement)

Car travel (\$0.66 per km from residence to course location return)

Airfare cost (cheapest economy airfare via most direct route)

Accommodation costs

(capped at \$140 per night; registered commercial premises only - NOT Air BnB)

Childcare costs (\$60 per day for up to five days per year)

Other Funding

Will there, or have other schemes been accessed to cover the cost of part or all of this event?

Yes

No

If Yes, component subsidised:

Scheme accessed:

Amount received / to be received:

Evaluation:

Please respond to the following statements				
1. Participation in this professional development (PD) activity has increased my job satisfaction				
Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2. The activity met the stated learning objectives:				
Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3. The activity has contributed to increasing my skill level and ability to implement evidence-based practice.				
Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4. This activity developed my ability to perform my responsibilities?				
Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5. How did the PD activity enhance your knowledge to address community health needs (50 words or less)				
6. Before this PD activity, when did you last attend a PD activity?				
3 months ago	6 months ago	1 year ago	More than 1 year	More than 2 years
7. If any, what were the barriers to attending MPD in the past?				
Location	Cost	Leave availability	Education availability	Other
8. Would you recommend this grant program to your Colleagues?				
Yes	No			
9. How did you find out about this grant program?				

Declaration:

- I have read and understood the Medical Professional Development Program Guidelines.
- I declare that the information supplied by me in this application is true and correct.
- I agree to future contact from the Rural Workforce Agency Victoria in relation to the evaluation of program outcomes.
- I am submitting all relevant receipts, a certificate of attendance and any relevant appendices with my application form.

Name of Applicant

Signature of Applicant

Date

Submission

Send completed applications and information to grants@rwav.com.au

Privacy Collection Statement

All personal information received by us from you or about you and your organisation will be stored, used and disclosed by us in accordance with our privacy policy, a copy of which can be found on our website at www.rwav.com.au/privacy-policy. If you have any questions in relation to how we may use and store your personal information, please contact us.

Appendix One – Statement of Support from Local Health Service

(Must be completed for **procedural training** only)

Medical Practitioner Details:

Name of Medical Practitioner:

Practice/Health Service name:

Practice/Health Service address:

Procedural Discipline:

Local Health Service:

Name of Health Service:

Address:

Name of designated officer:

The position of designated officer:

Contact number:

Email:

CPD activity endorsed:

Signature of designated officer:

Date:

Appendix Two – Distance Education Application Form

Medical Practitioner Details:

Name of Medical Practitioner:

Practice/Health Service name:

Practice/Health Service address:

Course/Module Details:

Name of course:

Course developed by:

Mode of Study:

Contact hours:

Non-contact hours:

Course description:

CLIENT EFT BANK ACCOUNT REGISTRATION

Rural Workforce Agency, Victoria, RWAV has the capacity to pay our creditor accounts by Electronic Funds Transfer (EFT) directly to nominated bank accounts. An EFT advice will be forwarded by fax or email within 3 working days that the transfer is made. RWAV will keep your account information strictly confidential, and will only be used for the purpose of payment of your accounts.

RWAV – Financial Operations Use Only			
Approved by:		Client Code:	
Position/Title:		Date Received:	
Signature:		Date Approved:	

CLIENT INFORMATION:

Name:

Postal Address:

Telephone:

Fax number:

Email:

Registered for GST Yes No
If yes, please provide ABN ABN:

BANK DETAILS:

Company Account Name:

or Account Name:

BSB number:

Account Number:

Bank Name:

AUTHORISATION:

I or on behalf of our Company, elect to receive payment(s) paying to us by EFT to our nominated bank account.

Name:		Signature:	
Position/ Title:		Date:	