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| Medical Professional DevelopmentSubsidy program |
| Application Form |

# Application Form

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. The subsidy will be up to a maximum of $3000 per applicant per financial year for eligible training. Total funding from the department is capped and there are limits of each eligible subsidy in an application.

This form should be completed and lodged with RWAV within 60 days of the training. Supporting documentation must be supplied with this application. This include:

* Copies of original receipts detailing GP’s name, name of training event, provider, dates and amounts paid
* Proof of completion of conference/event attendance (copy only).
* Copies of original receipts for accommodation must stipulate name of registered commercial provider, dates and total amount paid
* Copies of original receipts for travel and childcare.

## 1. Applicant’s details

|  |  |
| --- | --- |
| Name of Medical Practitioner: |  |
| Gender: |  |
| Date of birth: |  |
| Mailing address: |  |
| Practice / Health Service: |  |
| Practice / Health Service address: |  |
| Daytime contact number: |  |
| Email address: |  |
| Registered for GST: |  |
| ABN number (if applicable): |  |
| Rural stream registrar undertaking GP terms in RA 2-5: | If yes, is this CPD activity funded through vocational training? |

|  |  |
| --- | --- |
| Name of event: | Address and town |
| Location of event: |
| Date(s) of event: |
| Duration of event: |
| Topic / discipline |
| How is this training relevant to your general practice and to the local community’s health needs? |
|  |
| Evidence of attendance attached |  |
| Endorsed by local health service (procedural CPD only) |

1. **Other funding**

|  |
| --- |
| Will or have other schemes been accessed to cover the cost of part or all of this event? |
| Component subsidized: |
| Scheme accessed: |
| Total received / to be received: |

1. **Travel**

|  |  |
| --- | --- |
| Mode of transport: |  |
| Travel from: |  |
| Travel to: |  |
| No. of kilometres (return): | For car travel only |

\*Car travel subsidy is calculated at the rate of 66c per km from GPs usual place of residence or practice to the location of the event via the most direct and practicable route.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Component | Receipt Attached | Total Cost ($) | No. of Days | Amount claimed ($)\* | Office use only |
| Training event – procedural |  |
|  Training event – non-procedural |
| Conference – non-procedural |
| Travel – car |
| Travel – other |
| Accommodation |
| Childcare |
| **Total:** |

\*Amounts claimed should not exceed the caps specified in the guidelines

1. **Rationale**

Please explain how the knowledge/ skills that you have gained from the Professional Development (PD) activity will benefit your general practice and your local community’s health needs:

## Course Evaluation:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree  | Disagree | Neutral  | Agree  | Strongly Agree  |
| The PD activity met the stated learning objectives:  |  |
| The PD activity was effective/beneficial to continuing my medical education:  |
|  |
| The PD activity developed my ability to perform my responsibilities:  |
|  |
| Overall I was satisfied with the PD activity undertaken:  |  |
|  |  |

I certify that the above information is true and correct.

Name:

Signature:

## Further Information

For further information please contact: **Rural Workforce Agency Victoria (RWAV)** Telephone: (03) 9349 7800

Email: grants@rwav.com.au

(To be completed for procedural training only)

1. **Medical Practitioners Details** (to be completed by Medical Practitioner)

|  |
| --- |
| Name of Medical Practitioner: |
| Practice / Health Service name: |
| Practice / Health Service address: |
| Procedural discipline: |

1. **Local Health Service** (to be completed by the local health service)

|  |
| --- |
| Name of health service: |
| Address: |
| Name of designated officer: |
| Position of designated officer: |
| Contact number: |
| Email: |
| CPD activity endorsed: |
| Signature of designated officer: |
| Date: |

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Email: grants@rwav.com.au

This application form should be read in conjunction with the Department of Health and Human Services Medical Professional Development Subsidy program guidelines and the Rural Workforce Agency Victoria (RWAV) guidelines. This form should be completed and lodged with RWAV within 60 days that the educational activity/module/software is purchased. Payment t of subsidies is subject to RWAV/Departments discretion. Supporting documentation must be supplied with this application, including product description and cost.

## GPs Details

|  |
| --- |
| Name of Medical Practitioner: |
| Practice / Health Service name: |
| Practice / Health Service address: |

1. **Course / Module Details**

Name of course: Course developed by: Mode of study: Contact hours:

Non-contact hours:

Course description:

**Further Information**

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Email: grants@rwav.com.au

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. If you would like to have your accounts paid by EFT, please complete the following information and fax this form to **(03) 9820 0401** or email it to **info@rwav.com.au**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **RWAV – FINANCIAL OPERATIONS USE ONLY** | **Phone: (03) 9349 7800 Fax: (03) 9820 0401** |  |
|  | **Approved by:** |  | **Client Code:** |  |  |
|  | **Position/ Title:** |  | **Date Received:** |  |  |
|  | **Signature:** |  | **Date Approved:** |  |  |

 **CLIENT INFORMATION:**

**Company Name or Name:**

**Postal Address:**

**Telephone: Fax number:**

**Contact: Email:**

 **Registered for GST?**  [ ] No [ ] Yes  **ABN:**

If yes, please provide ABN

**BANK DETAILS:**

**Account Name:**

**BSB number:**

**Account Number:**

**Bank Name:**

 **AUTHORISATION:**

I or I, 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:** |  |