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| Department of Health  DecorativePostgraduate Nursing and Midwifery Scholarship  Application 2024 |

Scholarship applicants please note: You must submit your application to your health service.

If you wish to apply, please contact your education department or the Nursing/Midwifery Executive Officer responsible for your organisations scholarship program.

Closing date: 14th December, 2023

*\* Applications received after the closing date will not be considered*

**To maximise your opportunity to gain a scholarship, it is suggested you read the nursing and midwifery postgraduate scholarship program section of the Training and Development Funding: 2022-23 Program Guidelines thoroughly.**

Application submission:

These should be marked CONFIDENTIAL and addressed to:

Email: [*kim.spalding1@wh.org.au*](mailto:kim.spalding1@wh.org.au) *for ICU*

[*Nicole.cook@wh.org.au*](mailto:Nicole.cook@wh.org.au) *for ED*

[*Christopher.murray@wh.org.au*](mailto:Christopher.murray@wh.org.au) *for RENAL*

[*Jacqueline.Whitelaw@wh.org.au*](mailto:Jacqueline.Whitelaw@wh.org.au) *for PAEDIATRICS*

[*Debra.Broomfield@wh.org.au*](mailto:Debra.Broomfield@wh.org.au) *for MEDICAL, SURGICAL, AGED CARE, and all other courses*

Scholarship enquiries:

*Your relevant contact as above.*

Privacy statement

De-identified details from your application will be provided to the Department of Health (the department). *Western Health* will collect and retain your personal information contained in this application for the development of policy relating to the nursing and midwifery workforce. This information may be utilised for data collection, auditing and administration purposes. You can view the Department of Health Privacy Policy at <http://www.health.vic.gov.au/privstat.htm>.

**Income tax implications**

The department is not required to withhold tax (PAYG) from scholarships, as recipients require full pay for school fees. Not withholding tax does not mean scholarship is income tax exempt. If your scholarship is taxable, you will receive a payment summary that includes the amount of scholarship received from scholarship providers.

Recipients should be made aware that they:

    may be liable to pay tax on their scholarship. For more information refer recipients to the calculator on the ATO website: <https://www.ato.gov.au/Calculators-and-tools/Is-my-scholarship-taxable/>.

    may be entitled to claim a tax deduction for self-education expenses – for more information please refer recipients to the ATO site at the following link: <https://www.ato.gov.au/individuals/income-and-deductions/deductions-you-can-claim/self-education-expenses>.

**The department strongly recommends that recipients seek independent tax advice in respect to their scholarship payments.**

## Applicant details

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| Title |  | Family Name | | |  | | | | Given Name/s | | | | |  | | | | | | |
| Residential Address | | | |  | | | | | | | | | | | | | | | | |
| Suburb | | | |  | | | | | State |  | | | | | Postcode | | | |  | |
| Postal Address  (If different than above) | | | |  | | | | | | | | | | | | | | | | |
| Work Phone | | | |  | | | | | Home or Mobile |  | | | | | | | | | | |
| Preferred E-Mail  **(please print)** | | | |  | | | | | | | | | | | | | | | | |
| Are you an Australian or New Zealand citizen or permanent resident? | | | | | | | | |  Yes  No | | | | | | | | | | | |
| If not is this pending? | | | | | | | | |  | | | | | | | | | | | |
| Are you of Aboriginal or Torres Strait Islander origin? *(Optional)* | | | | | | | | |  Yes  No | | | | | | | | | | | |
| Ahpra Registration Number **(Mandatory)** | | | | | | | | |  | | | | | | | | | | | |
| Profession | | | | | | | | |  Registered nurse  Midwife | | | | | | | | | | | |
| Have you received a scholarship or funding from the Department of Health in the past? | | | | | | | | |  Yes  No | | | | | | | | | | | |
| If yes, health services must contact the department to ensure eligibility at the following email: [vicworkforce@health.vic.gov.au](mailto:vicworkforce@health.vic.gov.au) | | | | | | | | | | | | | | | | | | | | |
| If your name and address were different than stated above at the time of the Department of Health/Human Services scholarship or funding, please record these details here. | | | | | | | | |  | | | | | | | | | | | |
| Employment details during course of study - 2024 | | | | | | | | | | | | | | | | | | | | |
| Name of Employer | | | | | | |  | | | | | | | | | | | | | |
| Position/Job title | | | | | | |  | | | | Grade/  Classification | | | | |  | | | | |
| Area of practice | | | | | | |  | | | | Location/  Campus | | | | |  | | | | |
| Employment status | | | | | | |  Full time  Part time  Casual/Bank | | | | | | | | | FTE | |  | | |
| Name & Title of Employer contact person  *(e.g. Nurse Unit Manager or Nursing/Midwifery Executive)* | | | | | | |  | | | | | | | | | | | | | |
| Is your employment for 2024 confirmed? | | | | | | |  Yes  No | | | | | | | | | | | | | |
| Is your employer/manager aware that you are undertaking a course with a supervised clinical component? | | | | | | |  Yes  No | | | | | | | | | | | | | |
| If not, provide explanation: | | | | | | |  | | | | | | | | | | | | | |
| Course details for 2024 | | | | | | | | | | | | | | | | |
| Name of course | | |  | | | | | Level of qualification | | | | |  | | | | | | |
| Name of tertiary institution (including campus and State) | | | | | |  | | | | | | | | | | | | | |
| Commencement date of course | | | | | | / / 20\_\_ | | Anticipated completion date: | | | | | | | | / /20\_\_ | | | |
| Course fees for 2024 – **a copy of your invoice must be provided to your health service to confirm your out-of-pocket expenses** *(Semester 2 fees can be estimated based on confirmed Semester 1 fees - exclude amenities fees)* | | | | | | Semester 1  2024 | | **$** | | | | Semester 2  2024 | | | | **$** | | | |
| Study load in 2024 | | | | | |  Part time studies  Full time studies | | | | | | | | | | | | | |
| Course Place | | | | | |  Full Fee Paying  Commonwealth Supported Place (CSP or HECS) | | | | | | | | | | | | | |

*Successful applicants are required to pay course fees or student contribution/HECS direct to university by the due date or defer payment by taking out a FEE-HELP or HECS-HELP loan.*

***All students must provide a University Tax Invoice with details of payment/loan amounts. Successful applicants are required to provide evidence of enrolment. Health services must confirm they have sighted this information for the scholarship to be provided.***

**Other sources of funding sought for this study**

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| Fees payment method for 2024 | |  Upfront payment to university  FEE-HELP Loan   HECS-HELP  Combination | | |
| Have you been awarded a scholarship, grant or professional development funds from **another source** for this course?  *E.g. Employer, Professional body etc.**Exclude loans from your employer/ other bodies that you are required to repay.* | | | * Yes * No * Applied but not yet confirmed if successful | |
| Amount | **$** | | Name funding source |  |

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| Details of relevant education / clinical background | | | |
| ***Provide details of the relevant POST REGISTRATION education you have completed or is in progress*** | | | |
| **Year of course completion** | **Name of course/program of study** | **Institution/education provider** | **Additional comments** |
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| ***Provide brief details of RELEVANT professional experience that demonstrates your career trajectory.*** | | |
| **Dates** | **Description of clinical/professional experience** | **Additional comments** |
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| To the best of my knowledge the information I have provided is true and correct. I have read the *Training and Development guidelines* and I agree to the conditions for successful applicants.  I understand that scholarships are allocated at the discretion of the selection panel and that the decision of the panel is final. | | |
| **Applicant’s Name:** | **Signature:** | ***Date:***  / / |
| To the best of my knowledge the information provided is true and correct. I have read the *Training and Development guidelines* and I agree to the conditions of monitoring and reporting them to the department. | | |
| **Executive Support / Director of Nursing/Midwifery \*\***  **Name and Title:** | **Signature:** | ***Date:***  / / |
| **Email address:**  **(Please Print)** | ***Phone:*** | ***Alt Phone:*** |

**\*\* Nurse/Midwife Executive support is mandatory.**

While your Nurse Unit Managers support is valued, their sign-off is not sufficient.