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| OFFICE USE ONLY |
| OrganisationNumber | **Date** | **Initials** |
| Application Rec’d |  |  |
| Acknowledgment Sent |  |  |
| Application Checked |  |  |
| More information Requested |  |  |
| Approved |  |  |
| **Approval emailed** |  |  |

**TRAINING AND WORKFORCE DEVELOPMENT FUND APPLICATION**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position held in Organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Organisation’s MSD Contract Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ELIGIBILITY CRITERIA

Please tick the criteria below that apply to you:

 Permanent staff member

 Paid Staff Member:

 Full-time (30+ hours per week)

 Part-time (15-29 hours per week)

 Fixed term contract (minimum 12 months, in first 3 months of contract?

 The course is **not** subsidised or funded from another source.

 Have you applied for funding previously? If so, please supply the details.

**NB You may be asked to provide evidence that you meet the eligibility criteria.**

1. COURSE DETAILS

In this section please provide details about the training course you wish to undertake. Please provide evidence about the course, e.g. a prospectus, quote, official course outline or similar, which includes information about the course fee.

2.1 Name of Course provider:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Course | Papers to be undertaken (if applicable) | Start Date | Course FeeGST incl |
|  | 1. |  | $ |
|  | 2. |  | $ |
|  | 3. |  | $ |
|  | 4. |  | $ |
|  | 5. |  | $ |
|  | 6. |  | $ |
| TOTAL APPLIED FOR | $ |

* 1. Completion Date:

2.3 Where is the course being held?

* 1. Will the course result in NZQA credits?

Yes

No

1. **This application includes:**

An attachment with course information including fees

3.1 How will undertaking this course benefit your work?

* 1. How will undertaking this course help your organisation develop in line with the intentions of the NZ Disability Strategy and the principles of Enabling Good Lives?
1. **DECLARATION**

I declare that all the information provided is true and correct to the best of my knowledge.

Signature of applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NB If the applicant is the General Manager, please ensure that your Board Chair signs here.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **TO BE COMPLETED BY THE APPLICANT’S EMPLOYER**

5.1 How do you intend to support the applicant to undertake the course?

 Allow study time

 Allow time to attend classes

 Providing accommodation and travel costs if applicable.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this application to:

NZDSN, email to nicky@nzdsn.org.nz or post to PO Box 2653, Wellington