Health Professional Grant Application

Continuing Medical/Nursing;
Research and Allied Health Education;
Conferences, Courses Support and Resources

1. Applicant Details

Title ________ Family name ____________________ First names ____________________

Position ____________________ Department ____________________ Institution ____________________

Address (mailing) ____

Telephone ____________________ Fax ____________________ Mobile ____________________

Email ____

Describe your current role and involvement with childhood cancer:

____

2. Nature of Funding Requested

☐ **Conference** ☐ **Course** ☐ **Professional Membership** ☐ **Educational Material**

Brief details of funding request:

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Please attach conference or course brochures, professional membership invoice or details of educational material.
Please provide more details in section 4.0 below.

3. Relevance of Conference/Programme/Workshop to Child Cancer Foundation

Is the knowledge you will gain relevant to the wider Child Cancer Foundation community: ☐ **Yes** ☐ **No**

____

If yes, please describe how this information would be shared with
the members and/or employees of Child Cancer Foundation.

4. Amount of Funding Requested (conferences/courses)

Airfares		$
Registration/Fees		$
Accommodation		$
	TOTAL:	$

Please note other funding applications pending or approved, including DHB for any specific application:

Child cancer FOUNDATION

5. Conference/Course/Professional/Educational Details

Conference Title/Name ____________________

Dates ____________________

Venue ____________________

Relevance of programme to childhood cancer and other relevant details
(For example, presenting a poster, session chair etc – please provide poster/paper title)

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Applications for professional memberships and educational material – please provide details here

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6. Employer Contribution and Approval

If leave from your employer is required, has leave for this purpose been approved by your supervisor/employer?

____

Leave with pay? ☐ **Yes** ☐ **No** Employer's contribution ____________________

Please name 2 referees, with contact details (Please ensure that prior permission of referees is obtained)

Referee 1: ____________________

____

Referee 2: ____________________

____

7. Agreement by applicant

Name ____________________ Date ____________________

Statement for conference/course attendance:

I, ____________________ ,
confirm the above details are correct, and agree to submit a report to Child Cancer Foundation, within one month of completion of the conference/course outlining the major outcomes or highlights. I further agree to present relevant information to CCF staff and/or families if requested.

Note: On completion of pages 1 and 2 please discuss with the treatment centre health professionals, Dr Stephen Laughton or Dr Amanda Lyver for approval. Please complete entire application and forward to Child Cancer Foundation prior to travel and/or attendance. Retrospective applications will not be considered.

8. Endorsement. To be signed by 2 of the 3 authorised health professionals signatories

Name ______________________ Signature ______________________ Date ______________________

Name ______________________ Signature ______________________ Date ______________________

AMOUNT Approved $ ____

To be completed by the lead health professional. Tick (or highlight) budget category and location:

Budget

Health Professionals

- ☐ HP - Medical
- ☐ HP - Medical - COG
- ☐ HP - Medical - other conferences
- ☐ HP - Medical - Assoc/membership Fees
- ☐ HP - Medical - Other

HP - Nursing

- ☐ HP - Nurse - COG
- ☐ HP - Nurse - other conferences
- ☐ HP - Nurse - Outreach Study Days
- ☐ HP - Nurse - Other
- ☐ HP – Adolescent Nurse
- ☐ HP - General Expenses
- ☐ HP - Palliative Care
- ☐ HP - Allied Health
- ☐ HP - Research Grants
- ☐ HP - Research /Late Effects
- ☐ HP - CRA - Admin
- ☐ HP - Subs/Lic/Books
- ☐ HP - Consultancy/Salaries
- ☐ HP - Administration Support

Location

- ☐ Auckland
- ☐ Other North Island
- ☐ Christchurch
- ☐ Other South Island

Please send this completed application form to:

Child Cancer Foundation

P O Box 152

AUCKLAND 1140

Or email to: hpgrants@childcancer.org.nz

9. Child Cancer Foundation CEO Approval *(For CCF Office Use Only)*

Amount **$** ______________________ Name ______________________

Signature ______________________ Date ______________________

Child cancer FOUNDATION

Child Cancer Foundation
Conference/Seminar Expenses Itemisation

Name ____________________

Conference/Workshop Title ____________________

Date ____________________

Particulars	Foreign currency	Exchange Rate	Total NZ$ (GST inc)	GST (if applic.)	Net NZ$ (GST exc)	Receipt Attached
Conference Registration Fees						
Overseas Accommodation						
NZ airfares						
International airfares						
TOTAL						

Payment Instructions

Bank Account Number ____________________

Checklist for all applications

- ☐ All pages of application are completed
- ☐ Application is signed by 2 approved health professionals from either Auckland or Christchurch treatment centres
- ☐ All expenses itemized and all receipts and/or invoices attached including currency conversion if necessary
- ☐ Payment instructions completed