ST JOHN OF GOD Health Care

QUALIFICATION ALLOWANCE APPLICATION FORM
(St John of God Health Care Hawkesbury Nursing and Midwifery EA only)

Caregiver Name: _____ **Caregiver No:** _____

Position Title: _____

Ward/Department: _____

Division: _____

QUALIFICATION DETAILS
(to be completed by the Caregiver)

Qualification Title: _____

Qualification Level (e.g. Postgrad Diploma, Certificate): _____

Name of Institution: _____

Country: _____

Date Commenced: _____ **Date Completed:** _____

NB: A COPY OF YOUR HIGHER EDUCATION QUALIFICATION AND ACADEMIC TRANSCRIPT MUST BE ATTACHED TO THIS FORM

AUTHORISATION
(to be completed by the Director)

I hereby authorise the Human Resource Department to pay the above named Caregiver the following Higher Education Qualification Allowance:

- ☐ Enrolled Nurse - Certificate IV Qualification
- ☐ Registered Nurse/Midwife - Level 1. Postgraduate Certificate
- ☐ Registered Nurse/Midwife - Level 2. Postgraduate Diploma or Degree
- ☐ Registered Nurse/Midwife - Level 3. Masters or Doctorate

I confirm that the qualification is directly relevant to Caregiver's current practice/position/role as outlined in the SJGHC Hawkesbury District Health Service & ANMF NSW Nursing and Midwifery Enterprise Agreement.

Effective From: _____

Signed: _____ **Dated:** _____

DIRECTOR