

QUALIFICATION ALLOWANCE APPLICATION FORM
(St John of God Health Care NSW ANMF Nurses & Midwives 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 POSTGRADUATE 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 Qualification Allowance:

- ☐ Level 1. Graduate Certificate
☐ Level 2. Postgraduate Diploma
☐ Level 3. Masters or Doctorate

I confirm that the postgraduate qualification is directly relevant to Caregiver's current practice/position/role as outlined in the SJGHC NSW ANMF Nurses and Midwives Enterprise Agreement.

Effective From: _____

Signed: _____

DIRECTOR

Dated: _____