ST JOHN OF GOD Health Care

QUALIFICATION ALLOWANCE APPLICATION FORM
(SJGHC VIC Medical Scientists, Dietitians, Pharmacists and Psychologists EA only)

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

Position Title: _____

Ward/Department: _____ **Hospital/Service:** _____

QUALIFICATION DETAILS
(to be completed by the Caregiver)

Qualification Title: _____

Qualification Level (e.g. Graduate Diploma, Masters): _____

Name of Institution: _____

Country: _____ **Date Conferred/Awarded:** _____

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 payment to the above named Caregiver for the following Higher Qualification Allowance:

Medical Scientist
☐ Graduate Diploma, Masters, H.G.S.A. Cytogenetic Certification or Institute/Assoc. Membership (235)
☐ Doctorate, College Membership or Institute/Assoc. Fellowship (384)

Dietitian
☐ Graduate Diploma, Masters or H.G.S.A. Cytogenetic Certification (235)
☐ Doctorate, College Membership or Institute Fellowship (384)

Pharmacist
☐ Graduate or Fellowship Diploma (235)

Psychologist
☐ Graduate Certificate (252)
☐ Graduate Diploma (235)
☐ Masters or College/Board Membership (296)
☐ Doctorate (384)

I confirm that the postgraduate qualification is directly relevant to Caregiver's current practice/position/role and meets all criteria as outlined in the SJGHC VIC Medical Scientists, Dietitians, Pharmacists and Psychologists Enterprise Agreement.

Director Name: _____ **Signature:** _____

Date: _____

NB: Payment of the allowance shall commence from the first full pay period on or after this form and supporting evidence is received.