ST JOHN OF GOD Health Care

QUALIFICATION ALLOWANCE APPLICATION FORM
(SJGHC VIC Nurses EA – Registered Nurses & Midwives 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. Grad Cert, 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 Qualification Allowance:

- ☐ **Post Basic Hospital Certificate or Graduate Certificate**
- ☐ **Postgraduate Diploma, Degree, Double Degree or Honours Degree**
- ☐ **Masters**
- ☐ **Doctorate**
- ☐ **Endorsed Midwife** *NB: For caregivers who meet the definition of an Endorsed Midwife in sub-clause (a)*
- ☐ **Training and Assessment** *NB: Not applicable to caregivers in receipt of a higher/more generous allowance*

I confirm that the postgraduate qualification/certificate is directly relevant to Caregiver's current position and meets all criteria as outlined in the SJGHC Victorian Nurses 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.