APPLICATION FOR QUALIFICATION ALLOWANCE
St John of God Health Care
Registered Nurses and Midwives Agreement (WA Only)

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

Position Title: _____

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

Commencement in Position: _____

Date of this Application: _____

QUALIFICATION DETAILS - (To be completed by the Caregiver)

Qualification Title: _____

Qualification Type (e.g. Postgrad Dip, Certificate): _____

Name of Institution: _____

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

(***NB the Allowance is only payable whilst the qualification is relevant to your current practice/position/ role and is not payable during periods of unpaid leave e.g. unpaid parental leave or to casuals***)

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

AUTHORISATION - (To be completed by the Manager and Director)

I hereby authorise payment to the above named Caregiver a Qualifications Allowance of:

☐ **Level 1** Hospital based postgraduate qualification of one years' (or two academic semesters) duration or the renal dialysis certificate or a post graduate certificate awarded by a recognised university of at least one semesters full time duration of equivalent part time duration.

☐ **Level 2** Postgraduate diploma or second degree awarded by a recognised university, which must have been taken over a period of at least two semesters.

☐ **Level 3** Recognised Masters or PhD qualifications, which are relevant to the Caregiver's area of nursing practice or position or role.

I confirm that the qualification is relevant to the Caregiver's current practice/position/role as outlined in the SJGHC – ANMF - RN & Midwives Agreement

Nurse Manager: _____ **Dated**: _____

Allowance Effective from first full pay period on after:

_____

Director of Nursing: _____ **Dated:** _____