ST JOHN OF GOD Health Care

QUALIFICATION ALLOWANCE APPLICATION FORM
(St John of God Health Care VIC Allied Health Professionals EA Only)

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

Position Title: _____

Ward/Department: _____

Hospital/Division: _____

QUALIFICATION DETAILS
(to be completed by the Caregiver)

Qualification Title: _____

Qualification Level (e.g. Diploma, Doctorate): _____

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:

☐ Postgraduate Diploma or Masters (240)
☐ Fellowship or Doctorate (242)

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 Allied Health Professionals 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.