ST JOHN OF GOD
HOSPITAL
SUBIACO

APPLICATION FOR QUALIFICATIONS ALLOWANCE
St John of God Health Care Subiaco
Registered Nurses and Midwives Agreement

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

Position Title: _____

Ward/Department: _____

QUALIFICATION DETAILS
(To be completed by the Caregiver)

Qualification Title: _____

Qualification Level (eg. Postgrad Diploma, Certificate): _____

Name of Institution: _____

Country: _____

Date Commenced: _____ **Date Completed:** _____

NB: A COPY OF YOUR POSTGRADUATE QUALIFICATION 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 a Qualifications Allowance of:

- ☐ Level 1. Hospital Based Postgraduate Qualification.
- ☐ Level 2. University Postgraduate Qualification.
- ☐ Level 3. Masters or PhD Qualification.

I confirm that the Caregiver holds a postgraduate qualification that meets the criteria as outlined in the St John of God Health Care Perth Hospitals – ANF- Registered Nurses & Midwives Agreement 2016

Signed: _____ **Dated:** _____
DIRECTOR

HUMAN RESOURCE DEPARTMENT

☐ Alesco Effective Date: _____ Processed By: _____ Date: _____