



## APPLICATION FORM

The Toowoomba Hospital Foundation provides funding for the provision of equipment, staff education, training and professional development, health and medical research and scholarships.

When completing this Application please refer to the *Scholarship* Guidelines.

### Applicant Contact Details

Name:	
Position or Grade/Level:	
Workplace:	
Employee ID Number:	
Address:	
Phone:	
Email:	

### Application Details

Tick the relevant category:	<input type="checkbox"/> Undergraduate Studies <input type="checkbox"/> Post Graduate Studies <input type="checkbox"/> Full-time study <input type="checkbox"/> Part-time study
Proposed Award Course and Educational Institution, attach details:	
Expected duration of course:	

Describe benefit to health care delivery for the Toowoomba Hospital, Baillie Henderson Hospital or Mt Lofty Heights Nursing Home:

**Please Note:** If these questions are not answered, your Application will not be progressed.

1. Are any other funding options available to you (ie ROPP, SARAS, AO Training & Development)?  
 Yes  No
  
2. Have you applied for funding elsewhere?  Yes  No  
If yes, where have you applied: \_\_\_\_\_  
How much have you applied for: \_\_\_\_\_  
Were you successful in your application for other financial assistance?  Yes  No
  
3. Are you eligible for Professional Development Assistance under your Award/Certified Agreement with DDH?  Yes  No
  
4. If yes, how much do you receive \$\_\_\_\_\_
  
5. Have you used this allowance and if so for what purpose?  Yes  No  
(Please detail expenditure below of PDA including dates & amounts)

**Referees**

Provide name and contract details below:

Referee 1:	Contact Details:
Referee 2:	Contact Details:

**Costings (Grants are to a maximum of \$5,000)**

Actual Costs		Amount Requested	
Course Costs		Course Costs	
Course Materials		Course Materials	
Other costs		Other costs	
<b>TOTAL</b>		<b>TOTAL</b>	

*Note: Reimbursement of funds will be made to the Applicant upon successful completion of each study unit upon presentation of payment proof (ie tax invoice/receipt) and academic record.*

**Applicant Declaration**

I have read and understood the Guidelines for *Scholarship* funding and agree to abide by those conditions.

Name: ..... Signature: ..... Date: .....

**Line Manager Declaration**

This study is directly related to the current position held by the Applicant with the DDH.

Name: ..... Signature: ..... Date: .....

<b>Relevant Member of Darling Downs Health Executive or relevant Hospital Service Manager.</b>	<input type="checkbox"/> Endorsed	Signed:   Print Name:	Date:
	<input type="checkbox"/> Not Endorsed		

**\* Approval Signature required prior to sending Application to Toowoomba Hospital Foundation**

**Submission Contact Details**

Toowoomba Hospital Foundation Office  
 PO Box 7646  
 TOOWOOMBA QLD 4350  
 Tel: (07) 4616 6166

Email: [admin@toowoombahospitalfoundation.org.au](mailto:admin@toowoombahospitalfoundation.org.au)

Website: [www.toowoombahospitalfoundation.org.au](http://www.toowoombahospitalfoundation.org.au)

**Office Use Only: Toowoomba Hospital Foundation Office Staff**

Date received:	Signature
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