

**Allied Health Education Grant**

**Application Form**

This grant is available to assist with costs of attending conferences or another approved learning opportunity outside NZ. It is available to Allied Health Professionals working in the area of cystic fibrosis.

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| Name: |  | | | | | | | Phone: | |  | |
| Address: |  | | | | | | | Mobile: | |  | |
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|  |  | | | | | | | Email: | |  | |
| City: |  | | | | | | |  | |  | |
| Postcode: |  | | | | | | |  | |  | |
| ⬜ Doctor ⬜ Physiotherapist ⬜ Dietitian ⬜ Nurse | | | | | | | | | | | |
| ⬜ Social Worker ⬜ Psychologist  ⬜ Other | | | | | | | | | |  | |
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| Event that I wish to attend | | | |  | | | | | | | |
| Event details (dates / place) | | | |  | | | | | | | |
| I am requesting assistance for costs associated with:   ⬜ Registration ⬜ Travel ⬜ Accommodation ⬜ Meals | | | | | | | | | | | |
| ⬜ Other | | | | |  | | | | | | |
| Amount applied for: | | | | | $ | | |  | | | |
| Is your Employer willing to support your attendance financially: YES / NO  If no, why not? | | | | | | | | | | | |
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| Have you applied for or received funding from any other source? YES / NO  If yes, please list source and amount. | | | | | | | | | | | |
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| Tell us what you hope to achieve by attending this event and any specific skills you hope to acquire: | | | | | | | | | | | |
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| How will your attendance at this event benefit the wider CF community in New Zealand? | | | | | | | | | | | |
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| It is unlikely that you will receive full funding from Cystic Fibrosis New Zealand (CFNZ) as our funding budget is limited. What will you do if you only receive partial funding from us? | | | | | | | | | | | |
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| When do you need a decision by? | | | | | | | | | | | |
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| **COST BREAKDOWN** | | | | | | | | | | | |
| Item | | | | | | Provider | | | | | Amount Required |
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| **IMPORTANT NOTES** | | | | | | | | | | | |
| Please provide the following documents | | | | | | | | | | | |
| * Copy of the programme * Registration costs for workshops/conferences * Two competitive quotes for accommodation and travel costs (or if not possible, an explanation) * Covering letterhead on your organisation’s letterhead * Letter of endorsement from your Department Head (where appropriate) | | | | | | | | | | | |
| Please ensure you have attached all the information required, as failure to do so will mean that your application will be returned to you. | | | | | | | | | | | |
| Please ensure that you have answered all questions. | | | | | | | | | | | |
| Apply at least EIGHT weeks prior to the event you wish to attend. | | | | | | | | | | | |
| You will be required to submit receipts for expenditure covered by any grant received from CFNZ. These receipts are to be forwarded within three weeks of completing the event. | | | | | | | | | | | |
| **PAYMENT DETAILS**  If your application is successful, how would you like it paid? Payment can be made directly to the provider if their details are provided. | | | | | | | | | | | |
| Payment Method: | |  | Direct Deposit | | | | Account No: \_ \_ - \_ \_ \_ \_ - \_ \_ \_ \_ \_ \_ \_ - \_ \_ \_ | | | | |
|  | |  | Cheque | | | | Payable to: | |  | | |
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| Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Once completed, please mail this form and any attached documents to:

**Administration Manager,**

**Cystc Fibrosis New Zealand**

**PO Box 110 067**

**Auckland 1148**

**Or email to** [**admin@cfnz.org.nz**](mailto:admin@cfnz.org.nz)