

Licensed Practical Nurse and Personal Care Attendant Bursary Application Form

Revised: September 2015

The Bursary Program for LPNs and PCAs provides financial assistance to students who accept employment in difficult-to-fill positions in Newfoundland and Labrador.

The bursary is available to students enrolled in the 16 month Practical Nursing Programs offered by the Centre for Nursing Studies or the College of the North Atlantic, and students enrolled in the 33 week Personal Care Attendant/Home Support Worker Program that follows the provincial curriculum standards or equivalent training of Home Support Workers in community settings and Personal Care Attendants in nursing home settings.

- Recipients are required to provide proof of enrollment from their educational institution prior to any funds being issued. **Proof should be submitted with this application form.**
- Bursary value is a maximum of \$5,000, paid to the student by the Regional Health Authority (RHA) in two lump-sum payments of \$1000 each and one lump-sum payment of \$3,000.
- Each \$5,000 bursary will require the student to commit to a 3,900 hour service obligation as a LPN/PCA with a RHA in Newfoundland and Labrador upon completion of the program.
- Students must meet all conditions outlined by the RHA before being offered a bursary including, but not limited to, criminal record checks, proof of academic standing in the program, references and an interview process.

Education Program: _____

Name of School: _____

Location of School: _____

Program Completion: _____

(last day of exams in academic calendar)

____/____/_____
Day Month Year

PART A: STUDENT INFORMATION (PLEASE PRINT)

1. Surname: _____ Given Name: _____ Initial: ____

Previous Name (If applicable): _____

2. Social Insurance No.: _____ Female: _____ Male: _____
(Canada Revenue Agency regulations require the submission of a social insurance number for taxation purposes)

Date of Birth: ____/____/_____
Day Month Year

3. Address: _____

(H) Telephone #: (____) _____ - _____ (W) Telephone #: (____) _____ - _____
Cell Phone #: (____) _____ - _____ Email: _____

4. Name two persons (other than immediate relatives) who may be contacted to provide reference to your academic achievements / work experience.

Name: _____ Phone: (____) _____ - _____
Position: _____

Name: _____ Phone: (____) _____ - _____
Position: _____

5. Declaration by Student:

- I hereby declare that the information given on this application is true and correct to the best of my knowledge; and
- I will update any changes in contact information to the Department of Health and Community Services and RHA; and
- I have read the Bursary Program for Licensed Practical Nurses (LPNs) and Personal Care Attendant (PCAs) and agree to be in compliance with such policy; and
- I authorize the Government of Newfoundland and Labrador and the RHA to collect and share information about me as necessary, from any level of government in Canada, education institutions, references named in this application, and/or any other party identified in this application, for the purpose of verifying my eligibility for financial assistance and for verifying my compliance with the terms and conditions of receiving said financial assistance.

Date

Student Signature

Mail the completed form to the RHA where you plan to work to meet the service obligation.

Labrador-Grenfell Health Recruitment and Retention Coordinator Tel: (709) 285-8303 Mailing Address: Labrador West Health Centre 1700 Nichols-Adam Highway Labrador City, NL A2V 0B2	Eastern Health Human Resources Strategist Tel 1: (709) 777-3730 Tel 2: 1 888 866-1333 Regional Nursing Recruitment Consultant Tel 1: (709) 777-1613 Tel 2: 1 888 866-1333 Eastern Health St. John's, NL
Western Health Recruitment Officer Tel: (709) 637-5367 Western Health P.O. Box 2005 Corner Brook, NL A2A 1Y4	Central Health Recruitment Tel: (709) 292-5650 Human Resources Depart. Central Health 21 Carmelite Rd, Grand Falls-Windsor, NL A2A 1Y4

PART B: TO BE COMPLETED BY RHA

1. Is this person currently employed or been employed in the past three months with any RHA?

Yes _____ No _____

If yes, please indicate which authority:

Eastern Health: ____ *Central Health:* ____ *Western Health:* ____ *Labrador-Grenfell Health:* ____

Date employment commenced/ended: _____ to _____

2. Signature of Employer Representative

Date

Signature of Employer Representative

Name (Please Print): _____

Email: _____