



SA Public Sector Enrolled, Registered & Mental Health Nursing and Midwifery Scholarships 2010

Office Use Only

Vendor ID

Customer Ref:

Amount Granted:

Application Form
New and Continuing Studies



**Government
of South Australia**

SA Health

Part A – Application Form

Applicant Details *(Please print clearly)*

Title Ms Mrs Miss Mr

Surname: _____

First name: _____

Home address: _____

Home phone: _____

Fax: _____

Mobile phone: _____

Work place and
address: _____

Work phone: _____

Fax: _____

Email address: _____

Current position

Title RN/RM/EN): _____

Are you continuing studies for which you have received a scholarship in **2009**?

Yes

No

Current Practising Certificate Number _____

Employed:

FTE _____

Full time

Part time

Scholarship

Post Graduate Clinical

Mental Health

Enrolled Nurse

Sought:

Other

Do you identify yourself
as *(optional)*:

Aboriginal

Torres Strait Islander

Neither

Are you an Australian Citizen or a Permanent Resident:

Yes

No

Part A – Application Form

Course Details

Name of course:

Name of Education
Institution

Length of course (in full time years):

Current year of study
(if presently studying):

In what mode are you studying? External Internal

What is your study load for the academic year? *For example, enrolled in 18 units
i.e. 9 units in semester 1 and 9 units in semester 2*

Additional Information

Related to this course or study/application have you applied for, or are you in receipt of, any other state or federal grant/scholarship?

Yes No If YES, please provide details below

Title: _____ Amount: \$ _____ Expiry date: _____

Declaration

To be completed in full

I, (name) _____ declare that the information supplied by me in this application is true and correct.

I authorise the Scholarship Committee to seek details from the health service at which I am employed and educational institution at which I am enrolled/enrolling, including details of enrolment variations academic records, examination results, attendance and any other matters to assess my eligibility to apply for a SA Public Sector Scholarship.

Name of Applicant:

Signature of Applicant:

Name of Witness:

Signature of Witness:

Date:

Part B – Health Unit Notification

To be completed by health unit's Nursing & Midwifery Director or Divisional Director of Nursing & Midwifery or Director of Nursing and Midwifery or EO/ Director of Nursing and Midwifery:

I, (name) _____ have sighted
_____ (applicant's name) application and consider
them to:

- > have the expertise and competency to advance the concepts of the study into practice
- > meet the following criteria:
 - > registration/enrolment with the Nursing and Midwifery Board of South Australia
 - > holds a substantive position (on-going or permanent) and is currently working as a nurse or midwife within the SA Public Health Sector
 - > currently enrolled/enrolling in a clinical tertiary post-graduate nursing or midwifery course (or undergraduate if applying for an Enrolled Nurse scholarship) that requires the paying of fees.

I will support the applicant to undertake the study.

Divisional Director of
Nursing & Midwifery
(Metropolitan Health Units ONLY)

Date:

Nursing & Midwifery
Director
(Metropolitan Health Units ONLY)

Date:

Director of Nursing &
Midwifery or EO / Director
of Nursing & Midwifery
(Country Health Units ONLY)

Date:

Part C - EFT Authorisation Form



Government of South Australia

Department of Health

EFT AUTHORISATION FORM

PLEASE TICK APPROPRIATE BOX

ADD BANK DETAILS

CHANGE BANK DETAILS

FORWARD REMITTANCE ADVICE BY:

E-MAIL

FAX

POST

VENDOR NAME: _____

OFFICE USE ONLY

VENDOR ID: _____

ABN: _____

ADDRESS: _____

POSTCODE: _____

PHONE NUMBER: _____

FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____

I/We hereby agree for all payments by the Department of Health for goods and services supplied to the Department of Health to be made by way of direct credit to the bank account details below.

I/We hereby guarantee that the following details are bona fide, and agree to indemnify the Department of Health against any loss or damage suffered if the details provided are incorrect.

Name (please print): _____

Signature: _____

Title/Position: _____

Contact Number: _____

Date: _____

BANK DETAILS

Bank BSB Number:

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Bank Account Number:

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Bank Name: _____

Bank Address: _____

Post Code: _____

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