



<i>For Office Use only</i>	
Approval Date:	Fund:

**EDUCATION & TRAINING APPLICATION**  
 for Funding from the Drumheller Area Health Foundation (DAHF)

<b>APPLICANT INFORMATION</b>
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Individual Name:			
Title:		Unit:	
Email Address:			
Telephone Number:		Fax Number:	
Mailing Address:			
City/Town		Province:	
Postal Code:			

<b>EDUCATION OR TRAINING INFORMATION</b>
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Title of Proposed Education/Training:			
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Are you an employee in good standing of the Drumheller Health Centre. Yes  No

Has DAHF funded this Education/Training for anyone in your Unit in the past?	Yes <input type="radio"/> No <input type="radio"/>
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(If yes, for whom, was the experience positive, what action was brought back that could improve service to our patients and/or families?)			
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<b>Total amount of funding requested (Please enter details on page 2 of this application. This line automatically fills from that section.)</b>	(Total cost of registration and materials):	(Total cost of travel, meals mileage and lodging):
	\$0.00	\$0.00
<b>Total requested:</b>		<b>\$</b>

Are there other sources for this Education/Training? Yes  No

(If yes, please explain)			
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Will others be participating? (enter their names here - each must submit their own request for funding)	Additional Names:	Unit:

What benefit on both a personal and professional level does this proposed Education/Training help to move forward? (List all. Please be specific and use additional attachments)			
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**TRAVEL, HOSPITALITY & WORKING SESSION CLAIM ESTIMATE**

**SECTION A: Registration, fees and materials**

Expense & Travel Dates from:  to

Details of Education/Worshop session (registration, books and other fees related to the conference)	Amount of expense expected
<b>TOTAL FEES</b>	<b>0.00</b>

**SECTION B: LODGING AND TRAVEL EXPEENSES**

Travel and Lodging Dates: dd-mmm-yy	Description (include destination, detailed explanation of lodging, meals, air/taxi/auto, fuel, parking etc.)	Amount of expense expected:	Mileage:
<b>TOTAL EXPENSES:</b>		<b>\$0.00</b>	
			0.0
Meal Allowance are: Receipts are required.		ESTIMATED Mileage:	\$0.00
<b>TOTAL EXPECTED CLAIM</b>		<b>\$0.00</b>	

**SECTION F: AUTHORIZATION**

**Recipients that have received moneys from the Drumheller Area Health Foundation agree to provide a written report or in person presentation descibing the benefits both on a personal and professional level as a result of attending the education event when submitting their expenses for reimbursement. Approval is granted on a case by case basis and is at the discreation of the Board of the Drumheller Area Health Foundation.**

By signing this form, I attest that I am compliant to all of the above statements:

Applicant Signature:	Title:	Date:
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I approve the Applicant's travel, hospitality and working session claim and attest that it is in accordance with the Education policy of the Drumheller Area Health Foundation. I attest that the employee's expenses to be claimed are in compliance with the principles and mandatory requirements of this policy. I attest the expenses expected in this claim are for valid business purposes and will not be claimed from any other organization.

Approved By \_\_\_\_\_ Position: \_\_\_\_\_ Telephone#: \_\_\_\_\_

I, by signing this form, attest that I am copliant to all the above statements.

Supervisor's Signature:	Title:	Date:
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Please send completed claim form with original receipts and other required backup to the Drumheller Area Health Foundation's office. Claim forms may be found on the Foundations website at [www.drumhellerhealthfoundation.com](http://www.drumhellerhealthfoundation.com)