Expression of interest - Application Form

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| APNA Festival of Nursing Scholarships |

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| **Section A – Applicant Details** |
| **Applicant name:** |  |
| **Mobile phone:** |  |
| **Email:**  |  |
| **APNA Number*****(if applicable)*** |  |
| **Practice:** |  | **Position:** |  |
| **Section B – Application Responses** |
| What type of billing is the practice your primarily work in? | Bulk billing | [ ]  |
| Mixed billing | [ ]  |
| Private billing | [ ]  |
| What is the accreditation status of the practice your primarily work in? | Accredited | [ ]  |
| Seeking accreditation | [ ]  |
| Not accredited | [ ]  |
| Do you currently run nurse led clinics (NLC) atthe practice you primarily work in? | We run NLC | [ ]  |
| We want to run NLC | [ ]  |
| No intention to run NLC | [ ]  |
| Does the practice you primarily work in participate in SPDS? | Yes | [ ]  |
| Is interested in registering | [ ]  |
| Not participating | [ ]  |
| Does the practice you primarily work in participate in Lumos? | Yes | [ ]  |
| Is interested in registering | [ ]  |
| Not participating | [ ]  |

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| 1. **Based on the** [**festival of nursing program**](https://www.apna.asn.au/education/festival)**, provide an overview of which session(s) you are most excited to attend and why?**
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| *Please provide your response here:* |
| 1. **Based on your practice data which of the sessions would be most relevant to you and why?**
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| *Please provide your response here:* |
| 1. **Outline three expected outcomes of your participation.**
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| *Please provide your response here:* |

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| **Section C – Declaration** |
| ***This must be completed by the practice nurse and authorised practice representative*** | **Agree** |
| The applicant agrees to share their experience of participating in the APNA Festival of Nursing. This may take the form of a short presentation to the COORDINARE supported Practice Nurse Community of Practice, participation in an interview, or by writing an article for a COORDINARE e-newsletter.  |[ ]
| The applicant understands that COORDINARE may wish to contact me from time to time over the next 12 months for feedback on practice nurse related topics. |[ ]
| The applicant confirms they are willing to participate in a short 2-month quality improvement activity with their COODINARE Health Coordination Consultant.  |[ ]
| The applicant understands and accepts that information provided in this application may be stored by COORDINARE – South Eastern NSW PHN in various hardcopy and/or electronic formats. |[ ]
| The applicant understands they will be required to submit receipted evidence of scholarship expenditure to COORDINARE. |[ ]
| The applicant understands that if the conditions of the funding are not complied with, COORDINARE – South Eastern NSW PHN may seek to recover any funds allocated. |[ ]

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| **Applicant Name:** |  | **Date:** |  |
| **Applicant Signature:** |  |
| **Practice Representative Name:** |  | **Date:** |  |
| **Practice Representative Signature:** |  |