



## AOHNNL Bursary Program Application Form

|   |                                    |
|---|------------------------------------|
| <b>Created By:</b> Cathy Dormody, President | <b>Document No:</b> 100.01         |
| <b>Revised By:</b>                          | <b>Date Issued:</b> April 14, 2016 |
| <b>Approved By:</b> AOHNNL Executive        | <b>Date Revised:</b>               |

### Member Information

|   |                        |
|---|------------------------|
| Name:   | E-Mail:                |
| Home Phone No:  | Work Phone No:         |
| Address:  |                        |
| Employer Name:  |                        |
| Employer Address:   |                        |
| Currently Practicing in OHN: <input type="checkbox"/> Yes <input type="checkbox"/> No | Position Title:        |
| ARNNL Registration Current: <input type="checkbox"/> Yes <input type="checkbox"/> No  | ARNNL Registration No: |

### AOHNNL Involvement

|  |
|--|
| Monthly Meeting Participation: <input type="checkbox"/> 1-3 per year <input type="checkbox"/> 4-5 per year <input type="checkbox"/> 6-8 per year |
| Annual Professional Development Day: <input type="checkbox"/> Annually <input type="checkbox"/> Other _____                                      |
| AGM Participation: <input type="checkbox"/> Annually <input type="checkbox"/> Other _____  |
| Volunteers on Committees: <input type="checkbox"/> Yes <input type="checkbox"/> No Please List: _____  |
| Other: _____   |

### Program of Continuing Education

| Type  | Organizer/ Title   | Date |
|---|--|------|
| <input type="checkbox"/> AOHNNL Professional Development Day<br><input type="checkbox"/> COHNA – ACIIST Conference<br><input type="checkbox"/> Conference/Webinar/In-Service/Training<br><input type="checkbox"/> Certification Exam<br><input type="checkbox"/> OH&S/Nursing Program/Courses |  |      |
| Cost of Continuing Education:   | Copy of Receipt Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| Copy of Successful Completion Certificate / Grade(s) Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |      |
| Have you received financial assistance from any other source for this program? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |      |
| If yes, please provide name of organization/scholarship and amount?   |  |      |
| Have you previously received a bursary award from AOHNNL? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Date:  |      |

### Award Agreement

*I verify that all of the information is true and correct to the best of my ability. I have read and understand the Bursary Program application requirements and meet the eligibility criteria. I authorize AOHNNL to notify members and post my name on the AOHNNL website if I am a successful applicant. I understand that it is my responsibility to notify AOHNNL of any changes or withdrawal of this application.*

|                   |              |
|-------------------|--------------|
| <b>Signature:</b> | <b>Date:</b> |
|-------------------|--------------|

Mail Applications to:

**Association of Occupational Health Nurses Newfoundland and Labrador**  
 ARNNL House  
 55 Military Road  
 St. John's, NL A1C 2C5

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| Selection Criteria Guidelines   | Meets Criteria |    | Comments |
|---|----------------|----|----------|
| Completed application form in full.   | Yes            | No |          |
| Submitted application by May 1 <sup>st</sup> of applicable calendar year.   | Yes            | No |          |
| Type of professional development approved:<br><input type="checkbox"/> AOHNNL Professional Development Conference<br><input type="checkbox"/> COHNA – ACIIST Conference<br><input type="checkbox"/> Conference/Webinar/In-Service/Training<br><input type="checkbox"/> Certification Exam<br><input type="checkbox"/> OH&S/Nursing Programs/Courses | Yes            | No |          |
| Canadian based education.   | Yes            | No |          |
| Proof of attendance, completion, or successful passing of the program/course(s) attached.   | Yes            | No |          |
| Copy of receipt for professional development fees/costs attached.   | Yes            | No |          |
| Other financial assistance awarded from another source.<br>Name and Amount (if applicable):   | Yes            | No |          |
| AOHNNL Membership fees up to date.<br>Years of Membership: <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 5-10 <input type="checkbox"/> >10   | Yes            | No |          |
| Active member of the AOHNNL.<br><input type="checkbox"/> Attends regular meetings/AGM/Annual PDC<br><input type="checkbox"/> Volunteers on committees<br><input type="checkbox"/> Responds to AOHNNL inquiries and provides feedback<br><input type="checkbox"/> Other:   | Yes            | No |          |
| Previously received AOHNNL Bursary.<br>Date /Amount /Type (if applicable):  | Yes            | No |          |
| Currently practicing in Occupational Health Nursing   | Yes            | No |          |

### Additional Information (Optional)

|                   |              |
|-------------------|--------------|
|                   |              |
| <b>Signature:</b> | <b>Date:</b> |

### For Office Use Only

|  |  |
|--|--|
| Date Application Received:   | Category: AOHNNL Provincial Conference / Other |
| Application Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Date:  |
| Bursary Award Issued (attach a copy): <input type="checkbox"/> Yes <input type="checkbox"/> No | Date:  |

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