Please complete this form and submit via [MyHETIconnect](https://www.heti.nsw.gov.au/wpl-application) by **Friday 2 August 2024** to be considered. Sections A, B and C of this form will need to be entered into the online form. This completed application form will need to be uploaded into MyHETIconnect as an attachment.

2024/25 Allied Health Cross Boundary (CB) Grant Stream

Application form

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| **Section A: Group Details** | |
| **Local Health District / Specialty Health Network hosting event** |  |
| **Name / description of allied health team / group:**  \* Please note, only one application per team will be accepted and applications can only be received from NSW Health employees.  \*Only one application for WPL or CB – it can not be submitted through both streams |  |
| **Please list the Local Health District / Specialty Health Networks included in this application** |  |
| **If a minimum of 50% of the group is located in a Rural or Remote setting, please identify rurality using the Modified Monash Model** [Modified Monash Model | Australian Government Department of Health and Aged Care](https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm#how-to-find-current-areas-under-the-mmm) |  |
| **Key Contact Person** | |
| **Name** |  |
| **Work telephone** |  |
| **Work email** |  |
| **Alternative contact and details** |  |

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| **Section B: Cross Boundary (CB) Activity Details** | | | |
| **Name of Cross Boundary (CB) activity:** |  | | |
| **Theme** | ☐ Clinical Supervision  Communication  Counselling  Knowledge sharing e.g. onsite symposium  Mental health  Non-clinical workplace skill e.g. leadership, workplace culture, project management  Rehabilitation  Research  Specific clinical skill includes all other clinical skills that are specific to certain disciplines or settings e.g. casting, drug management or cancer treatment  Trauma  Other theme: or a sub theme related to above themes | | |
| **CB amount requested, inclusive of GST**  \*Do not include catering in quote as catering is not covered.  \*\*Do not include travel for participants as it is not covered only presenter travel will be considered. |  | | |
| **Location of CB activity** |  | | |
| **Number of people involved in CB activity**  \*Minimum number of participants is 3 |  | | |
| **Will participants include staff that identify as Aboriginal and/or Torres Strait Islander?** | No  Yes (how many?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Health professions involved in CB activity** | Allied Health Assistants | Art Therapy | Audiology |
| Aboriginal Health Worker/Practitioner in Allied Health team | Counselling | Diversional Therapy |
| Exercise Physiology | Genetic counselling | Music Therapy |
| Nuclear Medicine Technician | Nutrition and dietetics | Occupational Therapy |
| Orthoptics | Orthotics & Prosthetics | Pharmacy |
| Physiotherapy | Play Therapy | Podiatry |
| Psychology | Radiation Therapy | Radiography |
| Sexual Assault | Social Work | Speech Pathology |
| Welfare |  | |
| Nursing & Midwifery | Medicine |  |
| Other (please specific) |  | |
| **Are all members of this team employees of NSW Health?** | ☐Yes ☐ No\* %NSW Health Employees  \*If ‘No’, please explain the established working relationship between NSW Health and non-NSW Health team/group including its influence on patient care / workplace practices: | | |
| **Approx. % who are either allied health professionals or allied health assistants:**  \*Minimum 75% |  | | |
| **If the CB activity involves an external presenter/ facilitator, have you attached a quote to this application?** | Yes  ☐ No – this application will be ineligible if the presenter is not aware of this application  ☐ Not applicable | | |
| **If required, could this activity be conducted virtually** | Yes/No | | |
| **Will CB activity be completed by 30/06/2025** | Yes/No | | |

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| **Section C: Cost Centre Manager Contact Details** | |
| **Name of Cost Centre Manager** |  |
| **Email address** |  |
| **Telephone number** |  |
| **Cost centre number** |  |

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| **Director of Allied Health Endorsement** (from your district or network) | |
| **Name** |  |
| **Designation** |  |
| **Email address** |  |
| **Telephone number** |  |

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| **Section D: Cross Boundary (CB) Activity Details** | | | |
| 1. **Name of the proposed Cross Boundary activity.** | | | |
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| 1. **Please provide a detailed description of the proposed Cross Boundary learning activity** (including detailed plan and purpose of the activity. Clear information on name of education provider, audience, location, timeframes. Include a training outline where possible). *approx. 300 words* | | | |
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| 1. **Outline of existing working relationship between the group members.** Include frequency of working together and reason for connection. | | | |
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| 1. **Please provide justification based on evidence of why this Cross Boundary activity is important for your group and how it will improve clinical / workplace practices or patient care outcomes** (including reference to evidence based practice, literature, data and / or links to NSW Health documents). **Consider how the training would change current practice.** *approx. 500 words* | | | |
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| 1. **Please identify My Health Learning Module/s (if applicable) that are relevant to pre-learning and preparation for training.** If a module on the topic does not exist in MHL, or the module is not considered suitable as pre learning, please document this in the application. | | | |
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| 1. **Please state three learning objectives** **for the proposed Cross Boundary activity.**   *Learning objectives should be specific and measurable and where appropriate, linked to the evaluation* | | | |
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| 1. **Description of how the education and training can contribute to building the capacity of the service to support the delivery of clinical and other services for Aboriginal people** (e.g. closing the gap, access, cultural safety, community partnerships – for more information [Aboriginal health (nsw.gov.au)](https://www.health.nsw.gov.au/ABORIGINAL/Pages/default.aspx). | | | |
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| 1. **Please provide an overview of how you would evaluate this Cross Boundary activity** (including: purpose, evaluation focus questions, data sources, methods and dissemination). *approx. 300 words* | | | |
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| 1. **Please describe why this training is value for money of cost effective.** | | | |
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| 1. **Please provide an itemised budget of how the grant funds would be spent**. Quotations are essential and quotes should not include catering (it will be removed from requested amount if included) | | | |
| **ITEM** | | | **ESTIMATED COST** |
|  | | | $ |
|  | | | $ |
|  | | | $ |
|  | | | $ |
| **TOTAL COST – inclusive of GST** | | | **$** |
| **Please note:** Funding is up to $4,000 (or up to $4,500 if rural).  If total exceeds $4,000 (or up to $4,500 if rural) please indicate how additional funds will be accessed. | |  | |

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| **Key Contact Person Declaration** | | |
| I, as the Key Contact Person, declare that the information we have provided in this application is, to the best of my knowledge, true and accurate. In signing this application on behalf of the team, I confirm that we:   1. have sought approval for conducting this workplace learning activity from the line managers of all people included in this application 2. have support from Director of Allied Health 3. have support from the cost centre manager 4. have only submitted **one** application from our team/group 5. have not submitted an application in Workplace Learning program for same training 6. have read the *2024/25 HETI Workplace Learning Professional Development Terms & Conditions* 7. are not aware of any related interest, pecuniary or non-pecuniary, that may create, appear to create or have potential to create, a conflict of interest. 8. will complete an evaluation of this activity via survey link before 31 July 2025 9. will immediately bring to the attention of the HETI allied health team any change in circumstances 10. if you are no longer to act as a key contact person you have a responsibility to nominate an alternative key contact person | | |
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| **Name** |  | **Date** |