RURAL HEALTH WEST

Partner Education Grant

Application Form

Your Partner Education Grant application can be completed online at **www.ruralhealthwest.com.au/peg** or complete this form and submit to **familysupport@ruralhealthwest.com.au**

Applicant details

Title ________ **First name** ________________________________ **Last name** ________________________________

Current Employer ____

Email Address ____ **Mobile** ________________________

Residential Address ____

Residential Town ________________________________ **State** ____________ **Postcode** ____________

Are you of Aboriginal or Torres Strait Islander origin?
☐ Aboriginal ☐ Both Aboriginal and Torres Strait Islander
☐ Do not wish to specify ☐ Neither Aboriginal or Torres Strait ☐ Torres Strait Islander

Culturally and linguistically diverse (CALD) No Yes Do not wish to specify

Health Professional Partner's Full Name ____

Partner's Profession Aboriginal Health Worker Allied Health Professional Dentist
General Practitioner Hospital Doctor Medical Practitioner Midwife Nurse

Partner's AHPRA Number or Professional Association Number ________________________________

Partner's Practice Name ____

Education details

Name of education ____

Brief description of education ____

Name of education provider ____

Estimated cost of education $ ______________

Start date of education ______ / ______ / ______ **End date of education** ______ / ______ / ______

I agree that:

I meet the eligibility criteria as outlined on the Rural Health West website at **www.ruralhealthwest.com.au/peg**

To my knowledge, the information provided on this application form is true and correct.

I understand that as a successful Partner Education Grant recipient I will, if asked, provide my experience of the grant to be used for promotion by Rural Health West.

Signature ____ Date ______ / ______ / ______

The Partner Education Grants are delivered by Rural Health West with funding from the Australian Government Department of Health, Disability and Ageing.