Expression of interest - Application Form

|  |
| --- |
| APNA Festival of Nursing Scholarships |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 | |  |

|  |
| --- |
|  |
| 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?** |
| *Please provide your response here:* |
| 1. **Based on your practice data which of the sessions would be most relevant to you and why?** |
| *Please provide your response here:* |
| 1. **Outline three expected outcomes of your participation.** |
| *Please provide your response here:* |

|  |  |
| --- | --- |
| **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. |  |

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