Health Science Professionals – BCGEU Members Only

HSPBA Professional Development Fund

EXPENSE FORM

Last Name: **First Name and Initial(s):**

Address: **City:** **Postal Code:**

Phone: **Email:**

Union Affiliation:

Course Date (YYMMDD)	Tuition Amount	Course Books Amount	Other Course Related Expense Amount	Description/Explanation
TOTALS		+	+	=

Freedom of information and protection of privacy - Declaration

I understand that: The purpose of the HSPBA Professional Development Fund is workforce development which will benefit the Health Science Professionals sector.
I declare that: The information that I have provided in this application form is, to the best of my knowledge, correct and complete, and that the amounts listed are for education or retraining that I received or that I will be receiving.
I agree that: I may be asked to repay some or all of the monies if I fail to complete a course or courses without justification.
I recognize that: If I receive money from the HSPBA Professional Development Fund, and I have received Employment Insurance (EI) as a result of a layoff, EI may attempt to recover the monies paid to me. (Please contact your local EI office for further details.)
I understand that: The information I have provided will be used to determine my eligibility for funding from the Joint Community Social Services HSPBA Professional Development Fund.
I agree that: By signing below I give permission for the exchange of information between The Fund, The Fund Administrator (BCGEU), my employer, educational institutions, and other funding sources for the sole purpose of verifying and/or investigating information in this application and related documents.
I certify that: the above is a true statement of disbursements made by me for the reasons noted above.
I certify that: I have attached to this form course registration and description (on school letter head), detailed receipts which clearly document the nature and timing of the goods or services provided, the dollar value for each service, proof that I paid these amounts, and, for educational services, the fact that I am the recipient of the services.

Signature of Applicant: _____ **Print Name:** **Date:**

MUST BE SIGNED MANUALLY BY RECIPIENT AND SUBMITTED WITH RECEIPTS

Office Use Only PAYMENT APPROVED BY FUND ADMINISTRATOR

Signature: **Name:** **Date:**