CHRF +
Community Health Retraining Fund

# STATEMENT OF EXPENSE

FORM # CHRF ____ - ____
(UNION) (REF #)

Last Name: First Name and Initial(s):

Address: City: Postal Code:

Phone: Email:

**CHRF CANNOT REIMBURSE COURSES THAT HAVE BEEN PAID BY STUDENT LOANS.**

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

## Freedom of information and protection of privacy / Applicant Declaration

- ☐ **I declare that:** The information that I have provided in this application form is, to the best of my knowledge, correct and complete.
- ☐ **I agree that:** I may be asked to repay some or all of the monies which have been funded to me by the Joint Community Health Retraining Fund (The Fund) if I fail to complete a course, or courses, without justification.
- ☐ **I recognize that:** if I receive money from the Joint Community Health Retraining 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 Health Retraining Fund.
- ☐ **I agree that:** by signing below I give permission for the exchange of information between The Fund, 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 agree that:** I will participate in a follow-up survey to help the Joint Community Health Retraining Fund committee determine the success of the program.
- ☐ **I agree that:** I will stay in the health sector for a minimum of 3 times the length of retraining or be responsible for repayment.
- ☐ **I certify that:** I have not already received, and will not receive, funding or reimbursement to cover any of the expenses for which I am requesting reimbursement, either from another union, my employer, or another funding source.

Signature of Applicant: Date: Print Name:

MUST BE SIGNED MANUALLY BY RECIPIENT AND SUBMITTED WITH RECEIPTS

**OFFICE USE ONLY** PAYMENT APPROVED BY FUND ADMINISTRATOR

Signature: Name: Date: