

APPLICATION FORM
Grow Your Own NP – Full Time Option



Date of Application _____

Sponsoring Agency Information	
Sponsoring Agency Name	
Address	
City	
Postal Code	
LHIN	

Contact Information	
Sponsoring Agency Contact Name	
Title	
Fax	
E-mail	
Phone #	

Contact Information	
Name of RN Candidate:	
Title	
Address	
E-mail	
Phone #	
Current Employer	

APPLICATION FORM
Grow Your Own NP – Part Time Option

Sponsoring Agency

1. Is funding currently allocated to your agency/institution for a Primary Health Care Nurse Practitioner (PHCNP) position?

YES

NO

2. Has the NP position been vacant for at least 12 consecutive months (locums less than 8 weeks in length are excluded)? If yes, please state how many months.

YES _____ months

NO

3. Please describe your recruitment attempts to fill the position. For example, provide a list of advertising efforts, job fairs attended, and job website postings, etc. (Point form; 1/4 page maximum) **[Textbox]**

RN Candidate Details

4. Have you (the Sponsoring Agency) identified an eligible RN Candidate?

YES

NO

5. Is the RN Candidate currently employed at your agency?

YES

NO

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6. Does the RN Candidate meet the following eligibility criteria:

a. Has the RN Candidate been accepted to a PHCNP program? (Please attach documentation)

YES

NO

b. Does the RN Candidate live within 100km of the sponsoring agency's work site?

YES

NO

c. Has the RN Candidate agreed to sign the Return of Service (ROS) requirements outlined in the guidelines?

YES

NO

Program Details

7. Please describe why your agency requires the part time option. (1/4 page maximum)
[Textbox]

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8. If the RN Candidate is currently employed by your agency, please describe your contingency plan for backfilling the RN position.
(1/4 page maximum) **[Textbox]**

9. Are you (the sponsoring agency) able to offer at least one of the NP's clinical placements?

YES

NO

10. If no, please explain why a clinical placement is not possible. (1/4 page maximum)
[Textbox]

11. What is the total budget required for RN salary and benefits?

\$ _____(salary)

\$ _____(benefits)

\$ _____(total)

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SPONSORING AGENCY

I _____ confirm that the information contained
[Name of contact at Sponsoring Agency]

in this application is true and accurate to the best of my knowledge.

(signature)

(date)

RN CANDIDATE

I _____ confirm that the information contained
[Name of RN Candidate]

in this application is true and accurate to the best of my knowledge.

(signature)

(date)

By signing, both the Sponsoring Agency & the RN Candidate confirm that they are **not** currently in receipt of other Ministry funding for similar purposes (e.g. Tuition support program for nurses, Nursing Education Initiative, etc.)

The personal information about the RN Candidate that is submitted on this form is collected by the Ministry of Health and Long-Term Care, and is necessary for the Ministry's proper administration of the Grow Your Own Nurse Practitioner (GYONP) Program. This information will be used to determine eligibility for the GYNOP Program, for accountability and other related administrative purposes, including evaluating the success of the program. The Ministry will only disclose the information on this form to its employees and agents, who may in the future use it to contact the RN and/or the Sponsoring Agency to seek their views on the GYONP Program. In addition, if the RN is applying to work for the Prenatal and Postnatal Nurse Practitioner Project, the Ministry of Health and Long-Term Care will disclose the information on this form to the Ministry of Children and Youth Services for the purposes described above. Similarly, if the RN is applying to work at an Aboriginal Health Access Centre, the Ministry of Health and Long-Term Care will disclose the information on this form to the Ministry of Community and Social Services for the purposes described above.

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If you have any questions about this application form, including the notice regarding personal information, please contact Jennifer Yoon at 416-327-5855 or jennifer.yoon@ontario.ca.

Submission of Application

Please return the completed application form to:

Jennifer Yoon
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Nursing Secretariat
Ministry of Health and Long-Term Care
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Toronto, ON M5S 2S3
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