NOVA SCOTIA

CONTINUING EDUCATION PROGRAM
APPLICATION FOR COURSE REIMBURSEMENT (Page 1 of 3)

SECTION 1: APPLICANT/COURSE INFORMATION (to be completed by the applicant, one application per course)

I. APPLICANT

Applicant Name :	Address :		
	Street	City/Town	Postal Code

Email :	Telephone	
	Home:	Cell:

Current Early Childhood Education Training :	ECE Degree ☐ **or** Level 3 ☐	ECE Diploma ☐ **or** Level 2 ☐	Equivalent ☐ **or** Level 1 ☐	Untrained ☐ **or** Entry Level ☐

II. COURSE INFORMATION **Please complete one application per course**

Name of Course:			
Training Institution:			
Date of Course:	From (DD/MM/YYYY) :	To (DD/MM/YYYY) :	
Cost per course ($): (tuition only)		Cost of books/materials ($) :	
Did this course require travel of more than 100km one way?	☐ Yes ☐ No		
Did this course require your attendance in class during work hours?	☐ Yes ☐ No		

Please describe how this course will provide value to your current role/career path:

III. REQUIRED SUPPORTING DOCUMENTATION

A completed application must include the following :	Attached (√)
1) Evidence from the institution that this course was completed successfully.	☐
2) Receipts for the cost of the course and mandatory books/materials required for the course.	☐

IV. REQUIREMENT TO WORK IN LICENSED CHILD CARE

If reimbursed for this course I understand I will be required to work in a licensed child care facility or family home day care agency in Nova Scotia for 750 hours or 1500 hours as defined in the Continuing Education Program Terms & Conditions.	Agree (√) ☐

I, the undersigned, do hereby certify that all the information provided is true and complete to the best of my knowledge and belief. Signing below, I agree to comply with the Terms and Conditions of the Continuing Education Program.

Applicant Signature	Print Name	Date

CONTINUING EDUCATION PROGRAM
APPLICATION FOR COURSE REIMBURSEMENT (Page 2 of 3)

SECTION 2: LICENSED CHILD CARE FACILITY/AGENCY INFORMATION

Section 2 must be completed by the director or designate of the facility/agency where the applicant is currently employed. ***If this applicant was NOT employed at this facility/agency for a) a minimum of 6 months and/or b) at the start of this course, Section 3 must be completed.***

I. FACILITY/AGENCY INFORMATION

Name of Facility/Agency:		
Applicant was employed at this facility/agency :	From (DD/MM/YYYY) :	To (DD/MM/YYYY) :
Average number of hours the employee works per month :		

Has this course been reimbursed by way of another government funded program?	☐ Yes ☐ No
If yes, please indicate which program has provided funding for this course.	
Does this facility/agency support this employee and the course taken :	☐ Yes ☐ No
If no, please indicate why.	
Is the facility/agency applying for reimbursement for substitute coverage?	☐ Yes ☐ No
If yes, please provide the number of hours a substitute was required while this employee was attending classes.	

I, the undersigned, do hereby certify that this information provided is true and complete to the best of my knowledge and belief. Signing below, I agree to comply with the Terms and Conditions of the Continuing Education Program.

Authorization Signature	Print Name	Date
Position/Title:	Phone Number (902) :	

CONTINUING EDUCATION PROGRAM
APPLICATION FOR COURSE REIMBURSEMENT (Page 3 of 3)

SECTION 3: ADDITIONAL LICENSED CHILD CARE FACILITY/AGENCY INFORMATION

This section must be completed by the director or designate of any facility/agency where the applicant was previously employed. ***Only facilities/agencies that need to provide evidence that the applicant was employed at this facility/agency for a) a minimum of 6 months and/or b) at the start of this course, are required to complete this section.***

I.FACILITY/AGENCY INFORMATION

Name of Facility/Agency:		
Applicant was employed at this facility/agency:	From (DD/MM/YYYY) :	To (DD/MM/YYYY) :
Has this course been reimbursed by way of another government funded program?	☐ Yes ☐ No	
If yes, please indicate which program provided funding for this course.		
Is the facility/agency applying for reimbursement for substitute coverage?	☐ Yes ☐ No	
If yes, please provide the number of hours a substitute was required while this employee was attending classes.		

I, the undersigned, do hereby certify that this information provided is true and complete to the best of my knowledge and belief. Signing below, I agree to comply with the Terms and Conditions of the Continuing Education Program.

Authorization Signature	Print Name	Date
Position/Title:	Phone Number (902) :	

If you worked in more than one licensed child care facility or family home day care agency, please copy additional pages.

Please send the completed application to:

Coordinator, Family Home Day Care & Early Childhood Education
Early Childhood Development Services
Early Years Branch
Department of Education and Early Childhood Development
PO Box 578
Halifax, NS B3J 2S9

Should you require further information, please contact Kristina Creamer at (902) 424-5460 or e-mail at Kristina.creamer@novascotia.ca

SECTION 4: To be completed by the Department of Education and ECD ONLY

Course Approved	☐ Yes ☐ No	
Coordinator, Early Childhood Education	Updated (in system) ☐	
Signature	Print Name	Date