SEHD WORKFORCE DEVELOPMENT SERIES APPLICATION

Date of Application:	Name of Employee:
Address:	
City/State/Zip:	
Work Location:	
Employed full-time? ☐ YES ☐ NO	Stipend Amount Requested $_____

Employee Signature: _____ *Date:* _____

COURSE INFORMATION:

Development Series Title: _____

Date(s) of Series: _____ Location of Series: _____

Explanation of Series (attach any additional information): _____

_____

SUPERVISOR/APPROVAL (see checklist on back)

Supervisor Signature: _____

Approve: ☐ YES ☐ NO (if not, attach explanation)

County Nurse Manager/Program Director: _____

Approve: ☐ YES ☐ NO (if not, attach explanation)

WORKFORCE DEVELOPMENT SELECTION COMMITTEE APPROVAL

☐ $_____ Funds are available and will be encumbered for this employee

☐ **Budget #** _____

☐ Funds ARE NOT available at this time

☐ All applicable form(s) completed and employee meets policy guidelines

_____ _____

Workforce Development Selection Committee designee *Date*

HUMAN RESOURCES APPROVAL

Employee in good standing: ☐ YES ☐ NO (if not, attach explanation)

_____ _____

HR Manager Signature or designee *Date*

FINAL APPROVAL - SEHD MANAGEMENT TEAM

Approve: ☐ YES ☐ NO (if not, attach explanation)

_____ _____

District Health Director Signature or designee *Date*

To be signed by supervisor after completion of series and forwarded to Office of Growth, Learning and Innovation

STIPEND Note: Actual stipend conditional upon successful completion of series.

Evidence series completion occurred received: ☐ YES ☐ NO

Supervisor Signature: _____ _____

Approve: ☐ YES ☐ NO (if not, attach explanation) *Date*

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ACCOUNTING/PAYROLL USE ONLY

Date Received in Accounting: _____ **Date of Stipend Payment:** _____

Accounting/Payroll Staff Signature: _____

Supervisor Checklist:

Before employee registers for course(s):

- ☐ Employee has completed the **"SEHD Workforce Development Series Application"**
- ☐ Employee has completed the **"SEHD Workforce Development Series Application – Supplemental Information"**, if applicable
- ☐ Employee has been employed full-time or part-time for six (6) months with SEHD
- ☐ Employee received a minimum of "3" on most recent ePerformance document
- ☐ Employee has received NO corrective action within 12 months prior to request
- ☐ Verified that employee's participation in Development Series will not adversely affect SEHD services or activities if Series is during regularly scheduled work hours
- ☐ Employee has adequate accrued leave to allow participation
- ☐ Development Series request meets job/agency relatedness
- ☐ Forward form(s) to **Office of Growth, Learning and Innovation**
    - Email: DPH-SEHD-GLI@dph.ga.gov
      OR
    - Mail: **Attn: Emily Allen, Southeast Health District Annex B 1121 Church Street, Waycross, GA 31501**

After employee has completed the Series and in order for them to be reimbursed:

- ☐ **"SEHD Workforce Development Series Application"** and **"SEHD Workforce Development Series Application – Supplemental Information"** previously submitted and approved will be returned to supervisor and must be signed by supervisor again for reimbursement
- ☐ Evidence received of Series Completion
- ☐ Forward form(s) to **Office of Growth, Learning and Innovation**
    - Email: DPH-SEHD-GLI@dph.ga.gov
      OR
    - Mail: **Attn: Emily Allen, Southeast Health District Annex B 1121 Church Street, Waycross, GA 31501**

Upon final review, Office of Growth, Learning and Innovation staff will forward to Accounting/Payroll for Stipend payment.