

THIS FORM HAS BEEN DESIGNED TO BE COMPLETED ELECTRONICALLY.

ALL FORMS MUST BE SIGNED AND DATED.

ALL RED BORDERED FIELDS ARE MANDATORY.

THIS FORM MUST BE COMPLETED IN FULL PRIOR TO SUBMISSION TO THE [AHP+PDRP PORTAL](#)

To be completed by Applicant

PROFESSIONAL DEVELOPMENT (PD) DETAILS (title, brief description and justification of the PD activity)

Applicant Name

Date of Activity

To

Applicant Employee Number

Date

Applicant Signature

To be completed by Applicant's Director or Manager

DIRECTOR or MANAGER DECLARATION

I support the applicant in their application for funding in the AHP+ PDRP for the stated professional development activity/item(s).

I certify that the professional development activity/item(s) outlined above is in alignment with the applicant's need for registration or accreditation in the professional occupation in which they are employed and/or has a direct benefit to the employee's clinical skill, knowledge or career development as a clinician or clinical manager providing or supporting a clinical service to the consumers of the South Australian Public Health System.

Manager/Director Name

Position, Unit and Department

Date

Manager/Director Signature