



# Professional Development Fund Practice Application Form

**The Professional Development Fund (PD Fund)** provides reimbursement to midwives for professional development activities that enhance skill, knowledge, practice, and quality of care.

Please complete and submit this application as soon as the activity is complete. **Only complete applications will be processed.**

1 PRACTICE INFORMATION	
PRACTICE NAME	
ADDRESS	
CITY/TOWN	TEL

2 PD ACTIVITY INFORMATION		A: EVENT COST	B: TRAVEL Select one only	C: COST OF ACCOMMODATION	TOTAL \$ (A+B+C)
<b>ACTIVITY</b> Please provide proof of payment and completion. Photo, scan or fax accepted. <b>LOCATION</b> Provide city or postal code. <b>EVENT</b> Date DD/MM/YY			<i>Must have traveled more than 100 km one way to claim travel and accommodation expenses.*</i>		
1	MIDWIFE		<input type="checkbox"/> _____ km X .45: \$ _____ <input type="checkbox"/> Total fare (✈️🚗🚝): \$ _____		\$
	ACTIVITY		THIS SPACE FOR AOM USE ONLY		APPROVED
	LOCATION	DATE			
2	MIDWIFE		<input type="checkbox"/> _____ km X .45: \$ _____ <input type="checkbox"/> Total fare (✈️🚗🚝): \$ _____		\$
	ACTIVITY		THIS SPACE FOR AOM USE ONLY		APPROVED
	LOCATION	DATE			
3	MIDWIFE		<input type="checkbox"/> _____ km X .45: \$ _____ <input type="checkbox"/> Total fare (✈️🚗🚝): \$ _____		\$
	ACTIVITY		THIS SPACE FOR AOM USE ONLY		APPROVED
	LOCATION	DATE			
4	MIDWIFE		<input type="checkbox"/> _____ km X .45: \$ _____ <input type="checkbox"/> Total fare (✈️🚗🚝): \$ _____		\$
	ACTIVITY		THIS SPACE FOR AOM USE ONLY		APPROVED
	LOCATION	DATE			
SPACES BELOW FOR AOM USE ONLY					
AUTHORIZED		POSTED DATE	TOTAL APPROVED	CLAIMED AMOUNT: \$	
			\$		

\*The AOM uses <https://www.google.com/maps/dir/> to verify mileage claims.

3 DECLARATION	
I hereby certify that the practice group is eligible to receive this payment on behalf of the midwives on this application and that the professional development activities being claimed here have successfully been completed. I understand that any false or incomplete information submitted may invalidate this application and possibly constitute professional misconduct.	
PRACTICE PARTNER SIGNATURE	DATE DD/MM/YY

**? Questions about eligibility or other requirements?**  
See Eligibility and FAQs at [aom.on.ca/Continuing\\_Education/PD\\_Fund](http://aom.on.ca/Continuing_Education/PD_Fund)

4 HAVE YOU?		YES
1. Completed sections <b>1 2 3</b>		<input type="checkbox"/>
2. Attached proof of payment and completion for each activity		<input type="checkbox"/>
3. Attached all receipts including travel and accommodation if eligible		<input type="checkbox"/>

5 EMAIL OR FAX	
your application and <b>supporting documents</b> to <a href="mailto:pdfund@aom.on.ca">pdfund@aom.on.ca</a> or 416.425.6905	