Idaho Health Information Association
Professional Development Fund

The I.H.I.A. Professional Development Fund is designed to encourage participation in professional programs, meetings and courses by a greater number of the members. Because of geographic distances, it is often expensive and difficult for everyone to attend the limited number of educational activities offered within the state. The organization hopes to equalize opportunities through this fund and, thereby, increase and strengthen participation in the health information network.

The applications will be reviewed by the Executive Board and ranked according to the criteria. All applicants will be notified of the Board's decisions.

Eligibility Requirements

1. An applicant must be a current member of I.H.I.A.

2. An applicant can receive only one grant per year.

3. No institution may receive more than one grant per year.

4. A maximum amount of $150 will be awarded. The grant will not exceed the actual expense associated with the meeting, program or course for the which the grant is requested.

5. The local match must equal at least 25% of the amount of the I.H.I.A. grant.

6. Professional development funds may be used only for meetings, programs or continuing education courses sponsored by or co-sponsored by I.H.I.A. and may not be requested or used for any other purposes.

7. The application must be received at least 30 days before the event.

8. The full application must be typewritten.

Criteria for Selection

1. Is the application complete?
2. Is the individual eligible?
3. Does the applicant have the required local match?
4. Does the applicant define specific library needs in their institution?
5. First-time applicants will be given preference.

DRAFT: 6-24-93

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Application

Name ____

Job Title ______________________________ Full Time Part Time
(circle one)

Institution ____

Address ____

City ____________________ State ______ Zip ____________

Telephone ____________________ Fax ____________________

Library education/experience ____

____

Program/Course/Meeting ____

Location ______________________________ Date ____________________

Estimated cost ____________________ Amount requested ____________________

**** Please attach a personal statement describing how your library will benefit from your attendance at this activity. Address specific needs for your particular situation.**

I have read and agreed to the conditions stipulated by the Idaho Health Information Association Development Fund.

Signature ______________________________ Date ____________

Send completed application and personal statement to:

Kathy Nelson
Health Information Access Center
Columbia Eastern Idaho RMC
PO Box 2077
Idaho Falls ID 83403-2077