

APPLICATION FOR TUITION REIMBURSEMENT

All items in the following section must be completed before the application form will be processed.

REIMBURSEMENT APPLICATION FORM TO BE SUBMITTED TO ORGANIZATIONAL DEVELOPMENT ALONG WITH ORIGINAL RECEIPT FOR TUITION PAID WITHIN 2 WEEKS OF THE BEGINNING OF THE COURSE(S)

Name: _____ Title: _____
 Full/Part-time:* _____ Dept/Unit: _____ Shift: _____
 Work Phone: _____ Home Phone: _____ Cell Phone: _____
 Home Address: _____ State: _____ Zip: _____
 Date of Employment if within last six months: _____

*Full-time must be at least .85 FTE
 *Part-time must be at least .5 FTE

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Name of Institution: _____
 Course of study or certification in: _____

Course #	Title	Credit Hours	Graduate/ Undergrad	Total
				\$
				\$
				\$
				\$
				\$
				\$ _____

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I understand and agree that, in order to receive reimbursement, I must present a copy of **my final grade(s)** ("C" or better) to Organizational Development no later than thirty (30) days after completion of the course.

Applicant's Signature: _____ Date: _____

Approved: _____ Date: _____

(Vice President/Department Head/Nurse Manager)

**Full-time employees are required to complete one (1) month of service for each \$166.67 or fraction thereof reimbursed.
 Part-time employees are required to complete one (1) month of service for each \$83.33 or fraction thereof reimbursed.**

I understand that my employment at Erlanger Health System must continue until the time obligation is fulfilled, or I must reimburse Erlanger Health System for all months' service not worked, including remaining months of service from previous reimbursements. The remaining amount will be paid with interest calculated at prime rate in existence at the time of default, plus one percent. Monthly payments will be calculated over no longer than a 24-month period. Any single default in payment will cause the unpaid balance to be placed with an attorney or agency for collection, and I agree to pay all reasonable legal fees and court costs associated with the collection of the unpaid balance.

Applicant's Signature: _____ Date: _____

Witness: _____ Date: _____