APPLICATION FOR EDUCATIONAL ASSISTANCE

DEACONESS HEALTH SYSTEM, INC.
Evansville, Indiana

Name _____ Employee Number _____

Department _____ Department Number _____

Job Title _____ Date of Employment at Deaconess _____

Number of hours authorized to work per pay period _____ Daytime Contact Phone No. _____

Home Address _____
City State Zip

For Currently Licensed Nurses: Please indicate **CURRENT** status:
Licensure: RN _____ LPN _____ Degree: MSN _____ BSN _____ ASN _____ Diploma _____

THIS APPLICATION IS FOR: _____Type I _____Type II _____Type III _____Type IV

____Graduate ____Undergraduate ___Voluntary Nursing Certification ____Voluntary Certification ___ Voluntary Recertification

ENROLLMENT OBJECTIVE (Specify degree working toward and/or why you are taking class OR certification information):

_____

NAME OF SCHOOL OR CERTIFICATION ORGANIZATION _____

SCHOOL TERM: ( ) FALL ( ) SPRING ( ) INTERSESSION ( ) SUMMER

COURSE INFORMATION						
Course No.	Course Title	Date Begins	Date Ends	Credit Hours	Tuition Per Hour	Tuition Total
					$	$
					$	$
					$	$
					$	$
					$	$
				TOTAL REQUESTED	$	
				TOTAL APPROVED	$	

Are you currently receiving or eligible to receive financial assistance from any other student aid source?

____Yes ____No If yes, include any scholarships, grants or loans you are receiving or have applied for:

_____

Have you applied for Deaconess Tuition Reimbursement before? Yes _____ No _____

I have read Policy & Procedure No. 45-10, "Employee Educational Assistance Program and Educational Leave of Absence" and fully understand the policy and repayment procedures listed therein. I understand that should I terminate my employment prior to making the full repayment, the balance of the total dollar amount due will be deducted from my final paycheck unless other arrangements are made.

_____ _____
Signature of Applicant Date

COMPLETED APPLICATIONS ARE DUE IN THE HR BENEFIT OFFICE 2 WEEKS PRIOR TO THE START OF CLASS.
LATE APPLICATIONS ARE NOT ACCEPTED.
BEFORE YOU SEND FORM TO HR, YOUR MANAGER MUST COMPLETE AND SIGN TOP OF PAGE 2.

DEPARTMENT DIRECTOR/MANAGER RECOMMENDATION AND APPROVAL

Employee's Department Director or Manager **MUST** complete this portion of the application.

1. This Educational Offering meets which of the following:

   _____ Constitutes a job requirement
   _____ Will enhance the ability of the employee to perform their current job.
   _____ Will enable the employee to be promoted into a job that has been deemed difficult to fill
   _____ Will enable the employee to be promoted into another position at the hospital.
   _____ Is a voluntary certification exam.

2. This employee has __ _____; has not _____ satisfactorily completed their introductory period of employment and/or has _____; or has not _____ satisfactorily met performance standards on most recent performance appraisal as evidenced by an overall evaluation of _____

3. I recommend this application be: **APPROVED** _____ **NOT APPROVED** _____

4. Please list any comments you have regarding this employee or his/her application:

_____ _____
Signature of Department Director or Manager Date

HUMAN RESOURCES REVIEW AND RECOMMENDATION

_____ Verification of hours authorized to work per pay period
_____ Verification of date of employment
_____ Academic Program Evaluation on file (none on file – sent for completion_____)
_____ This course qualifies under degree objective as outlined in employee's Academic Program Evaluation.

Comments:

HUMAN RESOURCES DEPARTMENT FINAL APPROVAL

APPLICATION APPROVED _____ **APPLICATION REJECTED** _____

COMMENTS:

_____ _____
Signature, Human Resources Manager Date

TO BE COMPLETED BY HUMAN RESOURCES

_____Type of Grant

_____ Amount Approved

_____ Amount Spent In Last 12/18 Month Period

_____ Date Notification Sent To Employee (white)
And to Department Director/Manager (pink)
OR
_____ Date paperwork and check request sent to Finance

_____ Hours Authorized To Work At Time Class Ended

_____ Final Amount Paid

_____ Date Paid (Friday after PPE)