*APPLICATION FOR EDUCATIONAL ASSISTANCE – Deaconess Health System

Name_____Employee ID Number _____

Department_____Department Number _____

Job Title_____Date of Employment at Deaconess_____No. hours authorized per pay _____

Daytime Contact Phone No. _____ Email address: _____

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 Cert_____Voluntary Cert_____Voluntary Non-Nursing Recertification

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

_____

ANTICIPATED GRADUATION DATE FOR THIS DEGREE (month/year) _____

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 _____

Have you received a warning notice in the last year? 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. With my signature, I acknowledge that if I receive a warning notice between time of approval and time of payment, I will not qualify for reimbursement.

_____ _____

Signature of Applicant Date

COMPLETED APPLICATIONS ARE DUE IN THE HR OFFICE 2 WEEKS PRIOR TO THE START OF CLASS. LATE APPLICATIONS ARE NOT ACCEPTED. BEFORE YOU SEND FORM TO HR, YOUR MANAGER, DIRECTOR, OR VP 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 (required for all applications) Date

_____ _____
Signature of Vice President required (if non-supervisor or non-nursing graduate level application) 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

_____Hours Authorized To Work At Time Class Ended;

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

_____Final Amount Paid

_____Date Paid (Friday after PPE)

LOA: Yes No
Warning Notice in prior 6 months: Yes No
0413* (5/2014)