APPLICATION FOR EDUCATIONAL ASSISTANCE – Deaconess Health System

Name_____ Employee ID Number _____

Department_____ Department Number_____ Job Title_____

Date of Authorized Hours at Deaconess_____ No. hours authorized per pay _____

Daytime Contact Phone Number:_____ Email address: _____

For Currently Licensed Nurses: Please indicate **CURRENT** status:

Licensure: RN____ LPN____ *Degree*: Doctorate_____ MSN_____ BSN_____ ASN_____ Diploma _____

THIS APPLICATION IS FOR:

____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/YEAR: ( ) FALL_____( ) SPRING_____( ) SUMMER_____( ) INTERSESSION _____

Course Information						
Course No.	Course Title	Date Begins	Date Ends	Credit Hours	Per Hour	Total Tuition
					$	$
					$	$
					$	$
					$	$

Nursing Program Fees	$
Total Requested	$

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 corrective action 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 will be due. With my signature, I acknowledge that if I receive a corrective action between the 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 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.
_____Number of Corrective Actions

Comments:

HUMAN RESOURCES DEPARTMENT FINAL APPROVAL

APPLICATION APPROVED **APPLICATION REJECTED**

COMMENTS:

Signature, Human Resources Manager Date

TO BE COMPLETED BY HUMAN RESOURCES

_____ Amount Approved

_____ Amount Spent in Current Calendar Year

_____Date Notification Sent to Employee & Department Manager

_____Date Check Request Sent to Finance

_____ Authorized Hours at End of Class

_____Final Amount Paid

Corrective Action in prior 12 months: Yes No

_____PPE Date Paid

Leave of Absence: Yes No