

ST. ELIZABETH'S HOSPITAL
Tuition Reimbursement Application

Employee # _____

Date of Application _____

_____/_____/_____ / _____ / _____
 Name Department Position

Address City State Zip

Hire Date _____ Employment Status: Full Time Part Time _____ Budgeted Hours per pay
 PRN _____ est. avg. hours worked/per pay

Indicate the degree you are working toward and how it is of benefit to St. Elizabeth's Hospital:

Employer Required

Course Number and Name # of Cr. Hrs. School Name Employer Required

Course Number and Name # of Cr. Hrs. School Name Employer Required

Course Number and Name # of Cr. Hrs. School Name

From: _____	To: _____	\$ _____	\$ _____	\$ _____
Date Attending Class	Tuition/Hr.	Fee	Total Tuition/Fees	

Will you receive any form of tuition assistance for this course or courses?
 _____ No _____ Yes. If Yes, please list _____

I agree that if I terminate from St. Elizabeth's Hospital, I may be asked to repay St. Elizabeth's Hospital the tuition reimbursements for the preceding twelve (12) months on a prorated basis for all approved courses. (Excludes the computer classes that were "Employer Required.") Tuition repayment may be made in a lump sum to St. Elizabeth's Hospital or otherwise I authorize St. Elizabeth's Hospital to withhold the amount owed for tuition repayment from my final pay. Any or all reimbursement may be considered taxable income depending upon current IRS laws.

 Applicant's Signature

This application form must be approved by your department director and your asst. administrator BEFORE the starting date of any class.

OFFICE RECORDS - DO NOT COMPLETE - SEND TO DEPARTMENT DIRECTOR/MANAGER

Recommend approval _____ disapproval _____
 approval _____ disapproval _____

 * Department Director/Manager Date

 * Administrative Approval Date

* Explanation of disapproval:

Allowable Reimbursement \$ _____
 Maximum Allowance for year \$ _____

Signature _____
 Reviewer Signature Date