



Cheyenne Regional Medical Center

EDUCATION ASSISTANCE REIMBURSEMENT FORM

(SUBMIT TO HUMAN RESOURCES UPON SATISFACTORY COMPLETION OF COURSE(S))

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Employee ID # _____ Department _____ Current Position _____

Hire Date _____ Job Status: FT PT Degree: _____

I have completed the following course(s) previously approved for education assistance reimbursement.

Name of college institution: _____

Course Code	Course Title	Number Credit Hours	Cost per Credit Hour	Course Begin Date	Course End Date

PAYMENT RECEIPTS AND GRADES MUST BE ATTACHED FOR REIMBURSEMENT
(PLEASE PLACE NAME ON ALL RECEIPTS)

Course Expense(s): \$ _____ Books: \$ _____ Lab Fee(s): \$ _____

Total Reimbursement \$ _____

Employee Signature

Date

HUMAN RESOURCES USE ONLY

Amount Requested: \$ _____

Amount Approved: \$ _____

Total received to date: \$ _____

Commitment Period: ___6-months___12-months___18-months

Commitment Period start date: _____

Commitment Period end date: _____

Total Commitment period if added to prior commitment period