



Cheyenne Regional Medical Center

CHEYENNE REGIONAL MEDICAL CENTER EDUCATION ASSISTANCE APPLICATION

Name _____ Date _____ SSN _____

Address _____ City _____ State _____ Zip Code _____

Department _____ Current Position _____ Hire Date _____

Job Status: FT PT

College or University attending: _____

Expected Graduation Date (MM/YY) _____

Course Code	Course Title/Certification Title	Number Credit Hours	Cost per Credit Hour or Cost for Certification	Course Begin Date	Course End Date

Degree and major pursuing:

- Associate Degree in _____
- Bachelor's Degree in _____
- Master's Degree in _____
- Doctorate in _____

How does this degree apply to a position(s) with Cheyenne Regional? _____

___ I have read and understand the policy for the Education Assistance Program.

___ I certify that all information contained in this application is true, correct and falsification of information may result in denial or reimbursement and/or corrective action.

___ I understand reimbursement will be made for degrees that apply to positions which benefit Cheyenne Regional.

___ I understand reimbursement is allowed for tuition/cost of degree credit hours, lab fees and textbooks. All other costs, supplies, and fees will not be reimbursed.

___ I understand that to receive reimbursement I must remain in good standing from the time of application until successful course completion.

___ I understand that my coursework must not interfere with my job responsibilities and/or job schedule.

___ I understand there is a commitment to continue my employment with Cheyenne Regional based upon the dollar amount of education assistance received and that this commitment period is extended for each education assistance amount received in the future.

___ I understand that if I leave Cheyenne Regional employment prior to the end of my commitment period I will repay Cheyenne Regional the amount of educational assistance received on a pro-rated basis.

___ I understand that Cheyenne Regional reserves the right to amend or terminate the offering of the Education Assistance Program, and any reimbursement associated with this program, at any time.

___ I understand that this is not a contract of employment, and that all employment with Cheyenne Regional is voluntary and at-will, meaning that I or Cheyenne Regional have the right to terminate the employment relationship at any time, for any reason or no reason, and that this agreement does not alter that at-will employment relationship.

Signed _____ Date _____

DEPARTMENT HEAD AND EXECUTIVE TEAM MEMBER APPROVAL AND SIGNATURE

Is the above employee currently in good standing with Cheyenne Regional Medical Center? Y/N

Do you recommend the above employee for the Education Assistance Program? Y/N

1. Department Head _____ Job Title _____ Date _____

2. Executive Team Member _____ Date _____

3. Director of Human Resources _____ Date _____

Approved Denied Reason Denied _____
