Cheyenne Regional Medical Center

EDUCATION ASSISTANCE REIMBURSEMENT FORM

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

Name_____ Address_____ Date_____

City_____ State_____ Zip_____

Employee ID #_____ Department _____ Current Position _____

Hire Date_____   Job Status: FT/PT

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

Name of college/training institution: _____

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

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

Course/Certification Expense(s): $_____ Books: $_____ Lab Fee(s): $_____

Total Reimbursement $_____

_____   _____ Check ____/ACH ____
Employee Signature   Date

HUMAN RESOURCES USE ONLY

Amount Approved FY_____ $_____
Amount This Request: $_____
Amount Prior Reimbursements: $_____
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 _____
Notification of Commitment Period sent to employee: _____ Date _____

Human Resources Approval: _____   Processing Date: _____