



TUITION REIMBURSEMENT REQUEST FORM

Employee Name: _____

Date: _____

Title: _____ Dept: _____

Status: Full Time Part Time

College/University: _____

Degree/Certification Pursuing: _____

Course Number: _____

Course Description: _____

Credit Hours: _____

I have read and understand the Van Wert Health Tuition Reimbursement Policy. I understand that failure to comply with the Policy will result in funds being withheld from my paycheck until the total cost of all courses has been repaid to the hospital or if I am no longer employed, I must repay to the Hospital the total amount paid to me by the Hospital along with all accrued interest. My signature below represents my understanding and agreement to comply with the standards of the policy.

Employee Signature

Date

Manager Signature

Date

Vice President Human Resources Approval

Date

Request Denied

Date