

UINTAH BASIN MEDICAL CENTER TUITION REIMBURSEMENT REQUEST

EMPLOYEE INFORMATION -(Required)

NAME: _____ SS#: _____

ADDRESS: _____ HOME PH#: _____

CITY, ST, ZIP: _____

SCHOOL: _____ COURSE COMPLETION DATE: _____

DEPARTMENT MANAGER INFORMATION (Required)

Manager's signature indicates satisfactory job performance.

If not "met", do you want employee to be eligible for tuition reimbursement? ☐ Yes ☐ No

Department Manager's Signature: _____ Date: _____

DOCUMENTATION (Required - Attached to this form)

PAYMENT VERIFICATION

*Statement of Account (must include all of the following)

*Total Tuition Charges & Fees

*Amount Paid by scholarship/Grants, etc.

***Amount Paid by Employee**

Internet statement of accounts must include your name

GRADE VERIFICATION

(Provide one of the following)

* Report Card

*Transcript

Internet report of grades must include your name

PLEASE NOTE: Documentation must be received within 60 days of class completion or reimbursement will be forfeited.

FOR HUMAN RESOURCES USE ONLY

REIMBURSEMENT CALCULATION

Eligible Tuition: \$ _____ \$ _____
Percent x x

Reimbursement = \$ _____ = \$ _____ Total Reimbursement \$ _____

Comments: _____

Director of HR's Signature: _____ Date: _____