Scottsdale Healthcare Tuition Assistance Program Application

This is a: □ new application □ revised application (due to change in course information on previously submitted application)

You must submit your application as soon as possible but no more than 90 days before the course start. Please fax a copy of the completed application to Scholarship America. You will need to keep this application to request a reimbursement and/or report grades upon course completion. PLEASE PRINT – illegible writing may delay the processing of your application.

Section 1: Employee Data

Last _____ First_____ MI ____ Employee Number_____

Home Address_____ City_____ State_____ Zip_____

Last four (4) digits of SSN* _____ Home Phone ( )_____ Work Phone ( )_____

Hire Date _____Employee's email address_____

Supervisor's Name_____ Supervisor's Phone ( )_____

Supervisor's email address_____

Section 2: School Data

If applying for the first time or changing majors or degree, please submit your education plan (official list of courses required for degree) along with this application.

I wish to apply for . . . . . Please check one: □ **prepayment** (prepayment is only available for employees pursuing one of the specific areas below. Please check the area you are pursuing, if applicable.)

□ Nursing Career Track (NA, LPN, RN, RN-BSN)

□ Healthcare Career Track (healthcare/patient care)

Name of program_____

□ Work Study Program (two- or four-year degree, posted entry level jobs)

Requires T&D Approval_____
Signature of T & D Representative

□ **reimbursement**

School Name_____ City_____ State_____

Degree Sought: □ Associate □ Bachelor □ Graduate □ Certificate Major/Certification_____

Part A: Complete prior to course start date **Part B: Complete ONLY after course completion**

Course Number	Course Title	# of credits	Course Start/End Date (month/day/year) Start	End	Estimated Costs**	Actual Costs	Grade
1.					$	$	
2.					$	$	
3.					$	$	
4.					$	$	

** Estimate the tuition and clinical lab fees per course.

□ **I am…** □ **I am not …** **receiving other financial aid such as scholarships, grants, or V.A. benefits.**

Type of financial aid (if any)_____ amount of aid (if any) $_____

Section 3: Employee Verification and Authorization*

I acknowledge that I have answered all questions truthfully and accurately. I understand that falsification, misstatement, or omission of information on this application will lead to disqualification for receipt of education assistance benefits and/or may result in immediate termination of my employment. I authorize the educational institution named in this application to release transcript and fee information to Scholarship America if requested. I also authorize Scholarship America to 1) provide the last four digits of my Social Security Number to the educational institution listed above for purposes of providing to them the appropriate tuition prepayment when applicable and 2) use my home address for purposes of mailing my reimbursement or correspondence.

If a prepayment is being requested, please read the following terms carefully:

I further acknowledge that any funds prepaid to me for tuition assistance will constitute a valid and binding debt to Scottsdale Healthcare and any amounts prepaid to me are loaned to me solely for my benefit. In consideration of any amounts loaned to me, I promise to repay Scottsdale Healthcare, the full amount loaned if I (a) receive an unsatisfactory grade (as defined in the materials describing the Tuition Assistance Program) in any course(s) for which the loan was made, (b) fail to complete any course(s) for which the loan was made, or (c) am no longer on the payroll of Scottsdale Healthcare as a result of termination of employment whether by my resignation or for any other reason. I further authorize Scottsdale Healthcare to deduct from my wages through payroll deduction any amounts which have not been paid by sixty (60) days after the occurrence of any of the events listed above. In the event my employment is terminated for any reason, including resignation, I authorize Scottsdale Healthcare to deduct any remaining balance from my final paycheck(s) and/or severance payment(s) (if applicable).

Employee Signature_____ Date_____

Section 4: Supervisor Approval

I acknowledge that the employee meets the following criteria:

- is a regular full-time or part-time employee, exclusive of on-call or temporary status;
- is working a regular schedule of not less than 32 hours per pay period, exclusive of on-call or temporary status;
- has completed ninety (90) days or more of continuous service, exclusive of on-call or temporary status, as of the course start date and is in good standing with the company

OR

- is an employee not currently employed at least 32 hours per pay period in a full-time or part-time position who has been with the company for three (3) consecutive years previously working a regular schedule of 32 hours or more per pay period.

In addition, the employee is pursuing courses that are job-related or will provide improved work-related performance or personal career growth that will benefit Scottsdale Healthcare.

Print Supervisor's Name_____ Supervisor's Signature _____ Date _____

Section 5: Request for Reimbursement/Reporting of Grades

Within sixty (60) days after course completion, complete Part B of the School Data section on the first page of the application and send the application and documentation listed below by mail or fax using the contact information below:

_____ Official grade report for completed course(s)– must include the student's & school's name

_____ Itemized book receipts (with seller's name imprinted) – indicate which books are for each course

_____ Fee statement from school itemizing each course for tuition & eligible course fees - **for reimbursement option only**

PLEASE FAX COMPLETED FORM TO SCHOLARSHIP AMERICA AT 1-888-362-1748
(If you are applying for the first time or have changed majors or degree, provide your education plan with this application.)

For information contact Scholarship America:

Phone: 1-866-373-7853
8 a.m. to 4:30 p.m. Central Time
Monday – Friday (excluding holidays)

Fax: 1-888-362-1748

Mailing Address:
Scottsdale Healthcare Tuition Assistance Program
Scholarship America
One Scholarship Way, PO Box 297
St. Peter, MN 56082

Email: scottsdalehealthcare@scholarshipamerica.org