TUITION REIMBURSEMENT APPROVAL FORM

☐ Visiting Nurse Association of Central Jersey, Inc.
☐ Visiting Nurse Association of Central Jersey Foundation, Inc.
☐ Visiting Nurse Association of Central Jersey Health Group, Inc.
☐ Visiting Nurse Association of Central Jersey Personal Care, Inc.
☐ Visiting Nurse Association of Central Jersey Community Health Center, Inc
☐ Visiting Nurses & Homemakers Service, Inc.
☐ Robert Wood Johnson Visiting Nurses, Inc

Employee Name: _____

Department Number: _____ Date: _____

Home Address: _____

(If home address is not supplied, check will be sent to department)

Health Center/Dept: _____ Position: _____ ☐ Manager

☐ Full-Time ☐ Part-Time If Part-Time, number of hours/week: _____

Degree being sought: _____

College/University: _____

Semester: ☐ Fall 20____ ☐ Winter 20____ ☐ Spring 20____ ☐ Summer 20____

Name of Course(s):	Credits

Number of credits: _____ Rate per credit: _____

Description of Fees: _____

Total tuition requested:	$
Fees:	
Total requested:	$

Total amount approved (specify if prorated): $

Scheduled Hours _____ / 37.5 = _____ x Total requested

In addition to the information requested above, please list the number of credits that you anticipate taking in the future, during the next 2 semesters:

Semester: _____ Credits: _____ Cost: $ _____

Semester: _____ Credits: _____ Cost: $ _____

Class Time: _____ Travel Time Required: ☐ Yes ☐ No

Employee Signature: _____ Date: _____

Manager's Signature: _____ Date: _____

Senior Manager Signature: _____ Date: _____

Cc: Employee
Manager
Accounting
Human Resources