COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

APPLICATION FOR REGISTERED NURSE TUITION REIMBURSEMENT

ATTACHMENT A

*Application forms must be submitted four weeks before the course begins. INCOMPLETE OR ILLEGIBLE FORMS WILL BE REJECTED

Last Name		First Name	
Employee No.		Item No.	
Mailing Address			
Work Location			
Work Address			
Work Phone No.		Home Phone No.	
I am currently attending (School)		in one of the following programs:	
☐ Bachelors Degree in Nursing	☐ Masters Degree in:	☐ Doctoral Degree in:	

ATTACH A LIST OF THE REQUIRED CLASSES\\COURSES

Course Title		Course No.		Units	
Course Begins (MM\\DD\\YY)		Course Ends (MM\\DD\\YY)			
Course Meets: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S Time:					
Course Description					

Course Title		Course No.		Units	
Course Begins (MM\\DD\\YY)		Course Ends (MM\\DD\\YY)			
Course Meets: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S Time:					
Course Description					

Registration Fee	$

Are you eligible for reimbursement through veteran's benefits? If YES, attach verifying documents that you have exhausted these benefits.	☐ YES	☐ NO

Date		Employee Signature	

I recommend approval for this employee's application and certify that he\\she meets the department's Registered Nurse Tuition Reimbursement Policy guidelines (meets attendance standards and has passed the initial probationary period, has a current rating of competent or better on his\\her annual performance evaluation : ☐ YES ☐ NO			
If NO, reason denied:			
Date		Nurse Manager or Supervisor Signature	
Payroll Title		Print Name	

EMPLOYEE COMPLETES FRONT PAGE AND SUBMITS APPLICATION FORM TO FACILITY DESIGNEE OFFICE

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Employee Last Name		Employee First Name	
Reviewed and approved by Facility Nurse Recruiter or Authorized Personnel: ☐ YES ☐ NO			
If NO, reason denied:			
Date		Signature	
Payroll Title		Print Name	

Reviewed and approved by Chief Nursing Officer or Authorized Personnel: ☐ YES ☐ NO			
If NO, reason denied:			
Date		Signature	
Payroll Title		Print Name	

TR application form - Attach A