Appendix A

COFFEE COUNTY GOVERNMENT

EDUCATIONAL LEAVE/TUITION ASSISTANCE APPLICATION

DEPARTMENT OF HEALTH EMPLOYEES

1. Applicant's Name:_____

2. Type of Educational Leave Desired (check one or both)

   ▬ Part-time educational leave (a maximum of 7.5 hours/week leave time may be requested)

   ▬ Amount of tuition assistance requested (tuition excluding program fees for two courses not covered by the higher education fee waiver or grants). Additional support for 90% of tuition costs, up to $25,000/year may also be requested.

3. Position Title: _____

4. Assigned Division/Office: _____

5. Work Phone: _____

6. Home Phone: _____

7. Home Address: _____

   _____

   City State Zip Code

8. Education Highest level completed: _____

   Acceptance letter from University/Program Study: _____ Yes _____No

   If no, explain: _____

9. Service:

   Total years of service with the Department of Health: _____

   Total years of service with Coffee County (if different): _____

   Date of last performance evaluation: _____

   Overall rating on last performance evaluation: _____

10. Educational Program being pursued:

    Education Level: _____ Undergraduate _____ Graduate

    Degree being pursued: _____

    College/University: _____

    Status of application for admission: _____

    Anticipated date of enrollment (month/day/year): _____

    Anticipated date of completion (month/day/year): _____

11. Grants or Subsidies:

    Will you utilize any grants, subsidies or funding sources (other than the fee waiver)? _____

    If yes, please list the source: _____

12. Taxable Benefits:

    By signing the applicant acknowledges that the receipt of educational benefits in excess of $5,250 per year will be subject to federal income taxes as prescribed by the Internal Revenue Service (IRS). The taxable portion of these benefits will be subject to withholding in the applicant's paycheck on a quarterly basis.

13. One Year Commitment:

    By signing the applicant commits to at least one year of continued Coffee County Department of Health service following the last paid or time supported semester of the program.

APPROVAL

_____

Applicant's Signature Date Title

_____

Supervisor's Signature Date Title

_____

Division/Office/Regional Director Signature Date

_____

Coffee County Personnel & Benefits Coordinator Date