

LSUHSC - Health Care Services Division

Hospital: _____

Request for Tuition: _____ Exemption or _____ Reimbursement

(All appropriate spaces need be filled out before approval)

Employee Name: _____ SSN: _____

Home Address: _____ City/ST/Zip _____

Job Title: _____ Department: _____ Work #: _____

Educational Facility Attending: _____ Campus Location: _____

You are only allowed six (6) semester hours for the Fall/Spring and three (3) for Summer for reimbursement/exemption. You must provide a copy of your final grade(s) at the end of the semester. Your hospital should be informed of any changes in your school status.

Semester/Year: Fall ___ Spring ___ Summer ___ **Graduate ___ Under graduate ___

Program: Evening ___ Day ___ Independent _____

Dates of Class (month/day/yr): Beginning: ___ / ___ / ___ Ending: ___ / ___ / ___

(1) Course Title: _____ Course #: _____ Hours: _____ Cost: \$ _____

(2) Course Title: _____ Course #: _____ Hours: _____ Cost: \$ _____

(3) Course Title: _____ Course #: _____ Hours: _____ Cost: \$ _____

Explain Job Relevance or Value to Agency: _____

Employee Signature

Date

Immediate Supervisor

Date

Department Director

Date

Human Resources Director

Date

Chief Financial Officer
(Necessary only for Reimbursement)

Date

Hospital Administrator

Date

APPROVAL:(Necessary only for Exemption)

****Note: For all Graduate classes the tuition is considered taxable income**

Health Care Services Division
Human Resources Administrator

Date