ThomasHealth Foundation

Application & Agreement for Educational Grant Requests

ALL GRANTS ARE BASED ON A **REIMBURSEMENT** BASIS **(Please Attach Grades and Receipts)**

Applicants must be employed for at least ONE YEAR with full-time status

Name: _____

Address: _____

City/State/Zip: _____

Employee of: TMH _____ SFH _____ THSPP_____

Dept: _____ Title/Position: _____

Work #: _____ Home #:_____

Years Employed _____

Current Status: Part-time _____ or Full-time _____

Department Head Signature:_____ Telephone #:_____

Administration Signature: _____

How will this course benefit Thomas Health System? (If you need more room to write, please attach an additional sheet.)

Course/Seminar Name: _____

School/University Name: _____ Type of Degree: _____

Year of Study: __ *1st* __ *2nd* __*3rd* __*4th* __*5th* __ *6th*

Semester Start Date _____/_____/_____ Semester Completion Date _____/_____/_____

COMPLETE FOR COLLEGE CLASSES or SEMINARS

Total Cost for this College Semester or for Seminar (including books) $_____

Deduct Grants Received or Expected for this Semester from Hospital Education Dept. $_____ *(If already received the maximum from the Hospital, please check here_____.)*

Amount Requesting from The Foundation $_____ *(Up to $1,500 annually Jan.- Dec.)*

All receipts and/or invoices MUST BE attached before the application will be considered for approval

SERVICE AGREEMENT – Employees receiving grant awards will be required to exchange monies in the form of service to the Hospital. For every $1,500 received, the participant will need to provide 6 months of service or repay the total amount. The time of service starts upon successful

completion of the semester. If the employee should resign or their employment is terminated, they will be required to repay The Foundation the full amount of the grant.

I have read and fully understand the guidelines and service agreement provided to me as part of this application. If I do not meet the requirements, I authorize the Hospital to deduct $50 a pay period from my future wages until the balance is paid.

Employee's Signature: _____ Date: _____/_____/_____

Mailing Address: The Foundation for Thomas Health System
4605 MacCorkle Avenue, S.W., S. Charleston, WV 25309

Office Location: Medical Office Building, South
500 Poplar Street, Suite 300

Office: (304) 766-4340 Email: foundation@thomashealth.org Fax: (304) 766-4479

This section to be completed by The Foundation Office:

TUITION & BOOK RECEIPTS FOR THIS SEMESTER ATTACHED:	**☐YES**	**☐NO**	
TRANSCRIPT OF GRADES FOR THIS SEMESTER ATTACHED:	**☐YES**	**☐NO**	***☐FIRST TIME APPLICANT OR APPLYING FOR SEMINAR***
IF REIMBURSEMENT, TRANSCRIPT OF GRADES FOR THAT SEMESTER ATTACHED	**☐YES**	**☐NO**	

EMPLOYEE SIGNATURE WHEN CHECK IS RECEIVED: _____DATE CHECK RECEIVED:_____ AMT OF CHECK:_____