Association of Ohio Health Commissioners, Inc. Tuition Reimbursement Initiative 2024-2025
Local Health Department Staff Application & Agreement Form

PLEASE TYPE OR PRINT - Refer to Policy and Procedures to complete this form

Applicant Name:	**Date of Request:**
Applicant Address: (where the check should be mailed)	**Address Line 2:**
City/State/Zip:	**Applicant Phone:**
Applicant Email:	**Local Health District (LHD)/Agency:**

Other Reimbursement Received: Please check if you have received/will receive any of the following:

1. 2023 AOHC Tuition Reimbursement: ☐ Yes ☐ No If yes, amount received: $_____
2. 2024-25 AOHC Tuition Reimbursement: ☐ Yes ☐ No If yes, amount received: $ _____
3. Tuition Reimbursement from your health department or other source ☐ Yes ☐ No $_____

(Please explain within your application any reimbursement from your LHD and/or other source)

Total amount of reimbursement requested on this application: (total through AOHC cannot exceed $10,000):
(Total costs minus amount paid by other sources, e.g. scholarships, grants) **$**

2- year Service Commitment – Please enter your dates on the lines below:

1. Date of **completion** of the **first course** being reimbursed under this program (mm/dd/year): _____
(This refers to any AOHC reimbursement in 2023, or 2024-2025)

2. Date of hire at current Ohio Local Health Department (mm/dd/year): _____
If you have work time at another Ohio LHD prior to this start date & want to receive credit for employment served at the previous Ohio LHD, please enter that hire date here & provide documentation with your application: _____

1. What degree or certification is being pursued?
   - ☐ Associate degree
   - ☐ Bachelor's degree
   - ☐ Master's degree
   - ☐ Doctoral degree
   - ☐ Professional degree
   - ☐ Certification
   - ☐ Other, please list: _____

2. Please list your major/field of study or Certification sought: _____
3. Name of school or institution attended: _____
4. Please list **all** courses being submitted for reimbursement. (Please attach an additional sheet if type gets too small.)

5. Please list **all semesters/terms** being submitted for reimbursement on this form. Please use labels that match your documents, e.g.– Winter 2023, Spring 2023, Jan – May 6-month term, etc. Only submit an application for semesters that are completed or currently in progress at the time of submission.

_____

_____

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The documents outlined below must be submitted with this form. ***Please REDACT any personal information such as social security number or birth date.*** Submit documents via Survey Monkey.

Attach/Submit:

- ☑ Itemized bill and receipt/proof of payment from educational institution/provider showing term, tuition, fees/expenses, book requirements, and any grants/scholarships received. Please indicate classes included in payment and semester/terms or dates, and degree/certification being pursued.
- ☑ Record of completed courses that includes semester/term or dates, and final grade from educational institution ("C" or above or "Pass"/"Complete"). Student records are acceptable. Official transcripts are NOT necessary.
- ☑ This completed Application and Agreement Form with required signatures.

Applicant Agreement and Signature

My signature below signifies I understand and agree that:

- This request carries a 2-year service (employment) commitment to the current employing local health department or another Ohio local health department. The 2-year commitment begins as of either my employment date at my LHD, OR the date of completion of the first course paid for under this program, whichever is later. I may be responsible for repayment of this benefit on a pro-rated basis if employment is terminated prior to the end of my 2-year commitment, per the Tuition Reimbursement Initiative Policy and Procedures 2024-2025.
- I have received a copy and have read the established Policy and Procedures 2024-2025 for reimbursement and understand that I must follow those established policies and procedures in order to receive reimbursement.
- I cannot request reimbursement for any funds received from, or any costs paid by scholarship, grant, employer or other source for which I ultimately have no obligation to repay.
- Additionally, I understand this benefit is subject to funding availability and can be ended without notice.

_____
Employee Signature

Health Commissioner Approval (Required):

My signature below indicates that I approve this request as beneficial education/workforce development for our local health district and understand that if reimbursement is approved, it is our responsibility to monitor the 2-year employment commitment per the Policies and Procedures and notify AOHC if the 2-year commitment is not met.

Agency Name:	**Date:**
Health Commissioner Name: (print)	

_____
Health Commissioner Signature

For Internal Use Only:	❑ **Documentation Complete**	❑**Approved**	**Letter Sent:**
Approved by:			
	❑ **Disapproved**		
Reason for disapproval:			