REQUEST FOR PROFESSIONAL LICENSE OR CERTIFICATION REIMBURSEMENT

Name: ______________________________ Currently in Probationary Pd (first six months)? ☐ Yes ☐ No

Department: ____________________________________ Work Status: ☐ Full-Time ☐ Part-Time

Name of License or Certification: ____________________________ Expiration Date: _____________

Type: **License/Certification**: ____

Fee:$____

Other Costs (if applicable): ________________________________

____ I acknowledge that I have received and read the Health Care for the Homeless ("the Agency") Professional Development Policy.

_____ I understand that if I submit a notice of resignation that I will not be eligible for Professional Development or Professional License Reimbursement and the agency reserves the right to pro-rate any reimbursements that are in process as of the date of my resignation notice.

______ I understand that the Agency reserves the right to modify or terminate this benefit at any time.

STAFF SIGNATURE:____**DATE:** _______________________

SUPERVISOR SIGNATURE:____DATE:________________________

TO BE COMPLETED BY HR

Staff Member Hire Date: _____________ Staff Member Termination Date: _____________

Date Received: _______________ Payroll Processed Date: _____________

DIRECTOR OF HR SIGNATURE:_________________________________DATE: ____________________