



UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
REQUEST FOR TUITION ASSISTANCE

FALL
SPRING
SUMMER I
SUMMER II 20 _____

Human Resources MUST receive the Tuition Assistance form NO LATER THAN TEN DAYS PRIOR to the start of the course. Take a copy of the form after signed by department.

Part I To be completed by Employee

Date: _____

Name: _____ Social Security #: _____ Employee ID #: _____

Department Name and Code: _____ Position: _____

Mailing Address: _____
STREET CITY/TOWN STATE ZIP

Home Phone #: _____

Name of School	Title of Course	Date Course(s) Begin	End	Number of Credits	Tuition Only

CHECK ONE: ☐ Day Division ☐ Evening Division ☐ Online

Are you using this in conjunction with Remission/Waiver? ☐ Yes ☐ No

Are you working towards a degree? _____ Yes _____ No. If yes, specify degree _____

Give specific reason(s) for taking course(s) as they relate to your present work at the Medical School:

Signature of employee _____ Date _____

Part II To be completed by Department Head

_____ Recommended _____ Not Recommended

This course is directly related to the applicant's present job, meets a demonstrated need in my department, and is not available through in-service programs.

Signature of Department Head _____ Date _____

Part III To be completed by Human Resource Development

Employment date: _____ %Time: _____ Account number: _____

Previous tuition assistance received during current academic year:

Semester: _____ Amount received: _____ Balance: _____

Approved _____ for _____ amount _____ Not approved (Comments attached)

Signature Director, Human Resources or Designee

Date