

**Application for Employee Tuition Assistance  
for Attendance at the  
Pomeroy College of Nursing**

**INSTRUCTIONS:** Please complete PART A of this application. Forward the completed form to the Human Resources Department, 736 Irving Ave., Syracuse, NY 13210. The Human Resources Department will determine the extent of your eligibility for tuition assistance and then notify you and the Financial Aid Office at the College of Nursing. This form must be completed for each semester that you enroll in the College of Nursing, but should not be submitted more than 30 days prior to the start of each semester.

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**PART A:** To be completed by employee (Please print or type)

Name of Employee \_\_\_\_\_

Address of Employee \_\_\_\_\_

\_\_\_\_\_

Employee Social Security Number \_\_\_\_\_

\_\_\_\_\_

Employee Badge Number \_\_\_\_\_

Name of Qualifying Student \_\_\_\_\_

Student Social Security Number \_\_\_\_\_

Relationship to Employee \_\_\_\_\_

**AGREEMENT:** I understand that Crouse Hospital may require proof that the qualifying student is a spouse or dependent child of the employee and agree to supply such proof should it be requested.

My eligibility for this employee tuition assistance is dependent on my maintaining my current employment status through the end of the semester for which application is being made. If my employment status changes during the semester, I agree to refund to the hospital that semester's tuition assistance for which I become ineligible.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

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**PART B:** To Be Completed by Human Resources Department

Name of Employee \_\_\_\_\_

**Tuition Assistance Eligibility:**

NONE....Reason: \_\_\_\_\_

50%

100%

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

