

# ALAMO COMMUNITY COLLEGE DISTRICT

## EMPLOYEE TUITION ASSISTANCE PROGRAM

### APPLICATION FORM

**Check One:**

Pony

Pick-up



**INSTRUCTIONS**

1. Register for classes.
2. Complete the ETAP form.
3. Obtain Supervisor's signature
4. Submit to HR for approval no later than one business day prior to bill due date.
5. Please do not pay bill before obtaining approval from HR. You will not be reimbursed.
6. Take approved copy to Bursar. This is your money! We will not replace misplaced forms.
7. \_\_\_\_\_ Employee's initials

NOTE: This form is also used by eligible dependents.

EMPLOYEE'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

CAMPUS: \_\_\_\_\_ DEPT: \_\_\_\_\_ Daytime Telephone Number: \_\_\_\_\_

Application is for:  Self  Spouse  Single Child Under 25

NAME OF STUDENT: \_\_\_\_\_ SSN: \_\_\_\_\_

SEMESTER: (circle one)      Fall (includes FLEX I)      Fall FLEX II      Spring (includes FLEX I)      Spring FLEX II      Maymester      Summer I      Summer II

College(s) to be attended:  SAC  SPC  PAC  NVC

Credit Course Name/Number: \_\_\_\_\_

C.E. Course Name/Number: \_\_\_\_\_

Job-Related  Work Hours (Max of 48 hrs. per FY for Job-Related CE courses)

#### SUPERVISOR'S CERTIFICATION (Not required for dependents or retirees)

\_\_\_\_\_ As the supervisor, I assume the responsibility of assuring that this employee/faculty member will work the full hours paid.

\_\_\_\_\_ I hereby authorize release time of \_\_\_\_\_ hours for job-related, CE courses.

\_\_\_\_\_  
Supervisor's Name (Please print)

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

**APPLICANT'S CERTIFICATION:** I understand that I must reimburse the District for all expenses incurred due to courses dropped, not completed, or completed with less than a grade of "C" (this benefit does not include auditing classes). **I FURTHER UNDERSTAND THAT THIS APPLICATION IS ONLY GOOD FOR CLASSES LISTED ABOVE. THERE WILL BE NO PAYMENT FOR ANY CLASSES NOT APPROVED IN ADVANCE AND/OR CERTIFIED BY THE SUPERVISOR.** I understand that I **must** notify the Benefits Coordinator if any class changes are made. I authorize the District to deduct such reimbursements from my paycheck.

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ E-mail: \_\_\_\_\_  
(Please allow one business day for approval. We are unable to provide while-you-wait service.)

BENEFITS COORDINATOR: \_\_\_\_\_ DATE: \_\_\_\_\_

CASHIER: This authorization is funded at 100% for \_\_\_\_\_ hours and 75% for an additional \_\_\_\_\_ hours up to \_\_\_\_\_.

**NOTE: The maximum allowance for ETAP benefits for regular employees is \$1700 per fiscal year per employee, and per eligible dependent. Limited coverage is available for adjunct faculty and/or their dependents.**