St. Clair County Community Mental Health Authority

Application for Training/Endorsement/Certification Reimbursement

Employee Name:_____ Date:_____

Program Site:_____ Job Title/Grade: _____

Date of Hire:_____

Name of Training or Special Endorsement to be taken:_____

Dates of Training(s):_____

Expected Completion Date:_____

Professional Goal Statement: (Please tell us why you are interested in the program as well as any other relevant information you wish to include; attach additional sheet if necessary):

_____

_____

_____

Please Note: Additional documentation may need to be completed and more area specific questions answered for the training/endorsement as required.

_____

Staff Signature

ADMINISTRATIVE REVIEW

This application has been reviewed and tuition reimbursement is **GRANTED** for the following:_____

_____

_____

NOT GRANTED:

Rationale:_____

_____

_____

_____

Chief Executive Officer/Designee Signature:

Executive Team Review Date:_____

Class Completed:_____ Grade:_____

Reimbursed Date:_____ Amount:_____

cc: Employee
Supervisor
Personnel File